S. HRG. 113–613

PRESIDENT'S FISCAL YEAR 2015 HEALTH CARE PROPOSALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

APRIL 10, 2014

Printed for the use of the Committee on Finance

U.S. GOVERNMENT PUBLISHING OFFICE

93–936—PDF WASHINGTON : 2015

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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PRESIDENT'S FISCAL YEAR 2015 HEALTH CARE PROPOSALS

THURSDAY, APRIL 10, 2014

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:06 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Ron Wyden (chairman of the committee) presiding.

Present: Senators Rockefeller, Stabenow, Cantwell, Nelson, Menendez, Carper, Cardin, Bennet, Casey, Warner, Hatch, Grassley, Crapo, Roberts, Enzi, Cornyn, Thune, Burr, Isakson, and Toomey.

Also present: Democratic Staff: Joshua Sheinkman, Staff Director; Jocelyn Moore, Deputy Staff Director; Elizabeth Jurinka, Chief Health Advisor; Matt Kazan, Health Policy Advisor; Michael Evans, General Counsel; and Juan Machado, Professional Staff Member. Republican Staff: Chris Campbell, Staff Director; Kimberly Brandt, Chief Healthcare Investigative Counsel; Jay Khosla, Chief Health Counsel and Policy Director; and Anna Bonelli, Detailee.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

This morning the Finance Committee is here to discuss the health care proposals in the President's fiscal year 2015 budget. Secretary Sebelius, thank you very much for joining us this morning.

This discussion will undoubtedly trigger debate about the Affordable Care Act. Certainly there are going to be reasonable differences of opinion. What I would like to do is start with a handful of overlooked facts that are not in dispute about what has happened since the Affordable Care Act became law.

First, with the passage of the law, health care in America finally is no longer just for the healthy and the wealthy. Before the law was enacted, insurance companies could discriminate against Americans with a preexisting condition. That meant those who were healthy had nothing to worry about. Those who are well-off could pay their bills, and everybody else went to bed worried that they could be wiped out financially.

Second, the rate of growth in Medicare is slowing. The fact is that, according to the Department of Health and Human Services and their data, annual Medicare spending per senior grew by 1.9

percent over a 2-year period, slower than overall economic growth and much slower than historic growth.

Over the past 3 decades, per-senior spending grew 2.7 percentage points faster than the economy, so the fact that the rate of growth in Medicare is slowing has the potential to be great news for seniors who want lower premiums, and for taxpayers who want to extend the life of Medicare without breaking the bank.

Third, there are several important reforms that have been launched over the past few weeks. For example, building on work members of this committee have done—thank you, Senator Grassley, on this point—to open the Medicare database to Americans, the Obama administration yesterday made public unparalleled amounts of information that will help our people make choices about their health care. This is also going to help fight fraud, promote competition for Medicare services, and be a useful tool for the private sector. This information can be used by private employers and others to bring down the cost of insurance.

Another recent and promising announcement helps provide patients with life-threatening illnesses with more choices for their care. For the first time, patients will have access to hospice care without having to give up the prospect of curative treatment. This puts patients and families first, and it is high time.

Fourth, the Congress now has a bipartisan, bicameral plan for dealing with chronic disease. Thank you, Senator Isakson, for your work on this. We appreciate the input of Senator Bennet and Senator Warner. This legislation focuses on improving care for older people with multiple chronic conditions. This is the fastest-growing part of the Medicare population, and those older people deserve better and more affordable care.

Fifth, there is plenty of debate about which Americans enrolled in the Affordable Care Act and when, but the independent data shows that the number of insured Americans is significantly lower than it has been in years. For example, a Gallup poll released this week shows that the rate of uninsured Americans fell to the lowest level since 2008.

Finally, the Congress has made real progress on permanent repeal of the broken and dysfunctional Medicare physician payment formula. The reforms agreed to would push Medicare to be driven by the quality and the value of care. Today's volume-driven system is not good for seniors, it is not good for their doctors, and it is not good for Medicare. The President's budget proposal endorses a bipartisan, bicameral reform package, and we look forward to working with you, Secretary Sebelius, to get this done—get it over the finish line—by the end of this year.

Madam Secretary, in wrapping up, the last time you were here—Chairman Baucus, of course, chaired that hearing—I compared the roll-out of the Affordable Care Act to the expansion of Medicare to provide prescription drugs to America's seniors during the Bush administration. I focused on the bipartisanship that took place then, and the need for it to be repeated. And obviously, the Medicare prescription drug benefit, like the Affordable Care Act, zeroed in on the key concerns: expanding coverage and financial assistance to the needy and increasing marketplace choices.

The reality is that Medicare Part D has been an enormous success. For millions of seniors, it has been a godsend. It has cost less, 30 percent less, than the Congressional Budget Office predicted. We all know it had a pretty bumpy start, and many of the news stories from those early days of Part D resemble the kind of news stories that we see with the Affordable Care Act. The Congress did work in a bipartisan way across the aisle, regardless of how a member voted on Part D, and the program was able to get off the ground and become the success it is today.

Like the Medicare drug benefit, millions of Americans now have the economic security of health insurance they did not have just a few years ago. Regardless of politics or feelings about this law, that is something that is good for the economy and good for our country.

I am going to turn to Senator Hatch here in just a quick second. I did want to tell colleagues that we have this vote at 10:30, and it is the intention of Senator Hatch and I to just keep this going. We will have Senators coming in and out and just going in the order of appearance back and forth. But I wanted colleagues to know, given the interest in this subject and its importance today, we are going to just keep this going.

[The prepared statement of Chairman Wyden appears in the appendix.]

The CHAIRMAN. Senator Hatch, we welcome your comments and again express our thanks to Secretary Sebelius for being with us.

Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you, Mr. Chairman. I appreciate your wanting to keep this going, both as a courtesy to the Secretary, as well as members. I am grateful that you scheduled today's hearing. Secretary Sebelius, thank you for taking the time to be here today.

Now, this discussion is long overdue. Mr. Chairman, the President's budget was released on March 4th, 37 days ago. Typically, these hearings are scheduled within days after release of the budget. Indeed, it is generally considered to be routine to have budget hearings immediately. Yet, here we are now, more than a month later, finally sitting down to discuss the HHS provisions of the President's budget. Now, that type of lag time is disappointing, to say the least.

That said, the delay in holding this hearing is not the only delay that I am concerned about today. Madam Secretary, each time you have appeared before this committee, I have asked you to be prompt when responding to our communications, especially those dealing with the implementation of the Affordable Care Act. Yet numerous inquiries submitted to HHS by members of Congress have been ignored entirely, and we have yet to receive the answers to the questions submitted for the record after your last appearance before this committee on November 6th of last year.

This committee takes its oversight responsibilities very seriously, and I hope that in the future we can see a more cooperative and responsive approach to these efforts. Mr. Chairman, given how HHS has responded to our past attempts to exercise oversight, I

think we may have to schedule another hearing with the Secretary in the near future. That might be the only way that our members will get answers to the questions they submit after this hearing.

Now, Secretary Sebelius, process matters aside, I have some specific policy concerns that I hope you will be able to address today. For example, according to the President's proposed budget, combined spending for Medicare and Medicaid is expected to exceed $11 trillion over the next decade. To me, that is simply an astronomical number.

We are only talking about two separate Federal programs. Entitlement spending has become a generational challenge that demands all of our attention; however, the administration appears all too willing to continue to ignore these problems.

The proposed budget would save a meager $414 billion over the next decade, or roughly 3.7 percent of total Medicare and Medicaid spending, and it would do so primarily through provider cuts and government price controls. Anyone who has spent more than 5 minutes looking at our budget has concluded that these programs are in serious trouble and that they are, along with Social Security, the main drivers of our debts and our deficits.

The nonpartisan Congressional Budget Office, for example, has referred to our health care entitlements as our "fundamental fiscal challenge." I hope that during today's hearing we can get some answers about entitlement reform, because it is, quite frankly, one of the elephants in the room when we are talking about our Nation's fiscal future.

Another elephant in the room is implementation of Obamacare. Last week, President Obama took to the Rose Garden to spike the football and declare his health care law a "success" after it was announced that 7.1 million people had enrolled in the program. So far, the administration has spent at least $736 million on advertising for Obamacare, and some say more than that.

The *Healthcare.gov* website has cost more than $317 million. The call centers have cost at least another $300 million. So, using the most conservative estimates, the total cost of the website and the advertising have, to date, amounted to just over $1.3 billion.

That is a lot of taxpayer money, especially when you look at all the outstanding questions, like how many of these people will actually pay premiums? How many of them already had health insurance before the law went into effect? So far, it appears that the administration is hoping that the public will ignore these important questions and only focus on the number of claimed enrollees.

In fact, Madam Secretary, in your testimony before the House Energy and Commerce Committee, in response to some of these very questions, you stated that members of Congress would have to go ask the insurance companies, because you and your department were not keeping track of these figures, or at least that is how I interpreted it.

Now, it is my understanding that the 7.1 million enrollees touted by the administration and much of the press is merely a count of those who have selected an insurance plan through the exchanges, not of those who have actually purchased and paid for insurance. Now, that seems like a pretty odd number to celebrate.

Indeed, it is like *Amazon.com* taking stock of how many people have placed items in their shopping carts and then counting them as sales. In other words, it is a false metric. It is certainly not one that can justify the President's attempt to declare that the debate over his health care law is officially over.

There are many other questions that need answered with regard to Obamacare. For example, so far the administration has made more than 20 unilateral changes to the law. What is the cumulative cost of all those changes? While we are on the subject, how many more delays and changes are yet to come?

As you can see, there are a number of important matters to discuss today, both with regard to the President's budget and the implementation of Obamacare. I just hope we can have a serious discussion about these critical issues.

Madam Secretary, I do know that you have one of the most difficult jobs in Washington. I have worked with HHS all these years, and it is not an easy job. I appreciate you being here, and I know that you have been back and forth and sometimes not treated as well as maybe you should be. But we are grateful to have you here.

Mr. Chairman, I am grateful that you are holding this hearing.

The CHAIRMAN. Thank you, Senator Hatch.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. Secretary Sebelius, we want to welcome you. It is pretty evident that the topic of health care reform is not exactly for the faint-of-heart. We very much appreciate your working with us.

I particularly want to note this morning your focus on the reform of the delivery system of American health care. You have been working on this since the days when you were a Governor, and we are very appreciative of it because it is important today. It is going to be even more important tomorrow as we repeal and replace the flawed SGR system for reimbursing physicians, and then particularly zero in on chronic care.

So we appreciate your efforts, and why don't you proceed? We will make your prepared remarks a part of the hearing record in their entirety, and you can tell you are going to get a fair amount of questions. Thank you.

STATEMENT OF HON. KATHLEEN G. SEBELIUS, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Secretary SEBELIUS. Well, thank you so much, Chairman Wyden, Ranking Member Hatch, and members of the committee. I appreciate the opportunity to join you here today. I want to start by thanking members of the committee for your commitment to improving Medicare Advantage. Today, over half of all enrollees receive benefits from 4- or 5-star rated Medicare Advantage plans, thanks to our collaborative work together.

Our department's mission is to help our fellow Americans secure the opportunity to live happier, healthier lives and reach their fullest potential. Although the hard work of our employees is oftentimes unheralded, their efforts benefit millions of Americans.

Our Nation's seniors, for example, benefit from the hard work of employees at CMS and the Administration on Community Living, children benefit from the ACF-administered initiatives like Head Start, and all of us benefit from SAMHSA's work on mental health and substance abuse treatment, and from the efforts of employees across all our departments, operations, and staff divisions.

Another area that is benefitting all Americans is the implementation of the Affordable Care Act. Even prior to open enrollment in the marketplace, millions of Americans and their families obtained new rights and new consumer protections. Now, during these past 6 months, millions have obtained the security and peace of mind of affordable health coverage. Many of the people I have met have told me that they have been able to get coverage for the first time in years, and some have insurance for the first time in their entire lives.

Last week, we announced that 7.1 million Americans have signed up for private insurance through the marketplace. As of this week, 400,000 additional Americans have signed up, and we expect that number to continue to grow. Between October and the end of February, an additional 3 million Americans enrolled in Medicaid coverage. A total of 11.7 million people were determined eligible for Medicaid and CHIP. Now, we know that if more States move forward on Medicaid expansion, more uninsured Americans will be able to get covered.

Affordable health coverage, accessible health care, mental health, substance abuse treatment, food safety, early childhood care, and health security—all of these issues connect to President Obama's goal for expanding opportunity, strengthening our security, and growing our economy. The budget before you would move these priorities forward.

These investments create jobs and strengthen our primary care workforce by expanding the National Health Service Corps. We add to our mental health workforce by increasing the number of licensed behavioral health professionals, peer professionals, and mental health and addiction specialists. We protect the security of our seniors by investing in elder justice, and we invest in prevention efforts to protect the health of patients in nursing homes, primary care practices, and other health care settings.

The proposed expenditures also advance new approaches to some of our Nation's most vulnerable children, those in foster care. We are proposing investing in a new $750-million CMS/ACF partnership to encourage the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders, all with the goal of reducing the over-prescription of psychotropic medications. I want to particularly thank Senator Grassley and other members of this committee for expressing interest in the administration's focus on this area, and I look forward to working with the committee to address this need.

The budget also strengthens and expands important birth-to-kindergarten initiatives with strategic investments in priorities like the Child Care and Development Fund, home visitation, and Early Head Start partnerships.

President Obama's total child care request will enable a total of 1.4 million children to receive assistance. If you move forward with

the President's Opportunity, Growth, and Security Initiative, we will be able to provide an additional 100,000 children with access to high-quality early education through the expansion of Early Head Start partnerships.

Now, we know that these investments work. They pay dividends throughout a child's education and development, and they are proven to return an estimated $7 for every $1 we invest. I would say, Mr. Chairman, there are a lot of traders on Wall Street who would be envious of that kind of return.

In addition to a profound and lasting impact on children, these investments would also save lives, because most of the Early Learning Fund for partnership with States is paid for by increasing the tobacco tax, which we know is one of the most effective ways to prevent smoking, especially among young smokers. Today we will have 3,200 American children trying their first cigarette each and every day, and each day 2,100 of those children and young adults become daily smokers.

Now, it is no surprise that these early childhood investments have broad bipartisan support from Governors, CEOs, leaders in military and law enforcement, parents, and health care providers. Our global competitors are financing similar opportunities for their children.

Finally, this budget not only invests, but also saves. We will contribute a net $369 billion toward deficit reduction over the next decade. When you take all of these factors into account, it is clear that the budget before you is a security budget, an economic growth budget, and an opportunity budget which puts us on a pathway to a healthier and more prosperous Nation.

Thank you again, Mr. Chairman, for having me here today. I look forward to your questions.

The CHAIRMAN. Thank you, Madam Secretary.

[The prepared statement of Secretary Sebelius appears in the appendix.]

The CHAIRMAN. Let us start with Medicare because of its special importance. Madam Secretary, as you know, for millions of Americans, Medicare is a guarantee. It is going to be there. Americans do not have to worry about seniors and their families. Of course, our challenge is to protect the Medicare guarantee while dealing with what has historically been an escalation in costs. We have the demographics—more older people. We have the technology.

I am particularly interested in starting today by having you analyze the role of growth in Medicare spending, and particularly its slow-down. The Congressional Budget Office has said that Medicare spending is at a historic low and is projected to stay there. Just this week, we got additional news. The independent actuary for the Centers for Medicare and Medicaid Services said the same thing. This was part of the release on the Medicare Advantage announcement.

So what this suggests is the Medicare guarantee is being protected, costs are being held down, and the needs of seniors are not being compromised. So this certainly strikes me as encouraging for seniors who want lower premiums, and for future generations who want Medicare to be around when they need it.

So I think I would like you to really unpack why you think we are seeing this slow-down, and then, can it be anticipated to continue in the days ahead? Why don't we start with that?

Secretary SEBELIUS. Mr. Chairman, I think you are accurately reporting what has happened. In the 9 years between 2001 and 2009, the spending on average for Medicare enrollees was growing at about 6 percent a year. That was above the national GDP, and that had been traditional. What has happened in the subsequent 4 years is pretty dramatic. Between 2010 and 2012, expenditures grew per capita at about 1.6 percent, significantly below that 6 percent average. In 2012, it grew at 0.7 percent.

What the actuaries said in the recent statement regarding Medicare Advantage pricing—and this will be confirmed when the trustees meet later this spring—is that they are now adjusting the trend line once again. They think the growth trend will be a minus 3.4 percent. This is the lowest growth ever seen in the history of the program in 50 years.

At the same time, I think that seniors are enjoying additional benefits. They now have preventive services benefits with no out-of-pocket costs. They have more choices with Medicare Advantage. They have had a reduction in prescription drug costs, including closing of the donut hole, which is happening over time, averaging about $929 of senior savings for those in the donut hole.

We have done unprecedented work in waste, fraud, and abuse. We have increased competitive bidding, and we are improving quality and value. So I would say, all in all, it is very, very good news for seniors.

The CHAIRMAN. Let us go then to another important issue for seniors, and that is Medicare Advantage. During the course of the Affordable Care Act debate, we heard repeatedly that the legislation would be the ruin of Medicare Advantage as the country knows it. The evidence suggests just the opposite.

Since the Affordable Care Act was signed into law, Medicare Advantage premiums have fallen by almost 10 percent and enrollment has increased by 38 percent to an all-time high of over 15 million seniors, so we are almost now nationally at about 30 percent of seniors in an MA plan.

This is particularly important, as you know, to Oregon, because we have some of the best MA in the country, and we were pleased now that finally we are rewarding those high-quality plans, the 4-star plans, as well. Tell us what you think is ahead in terms of Medicare Advantage, and particularly how we might build on this progress.

Secretary SEBELIUS. Well, again, Mr. Chairman, I think that it was definitely predicted throughout the debate in 2009 and 2010 that any proposal to bring Medicare Advantage payment rates in line with fee-for-service would destroy the program, would make seniors give up their plans, and would harm Medicare Advantage.

Medicare Advantage, just by reminder, was put in place as a choice for seniors, and initially the private plans were going to be paid 95 percent of fee-for-service cost, because the promise was that Medicare Advantage would deliver better care at lower cost, and the competition would be good, and seniors could have a choice. Over time, by 2009, Medicare Advantage plans were being

paid 114 percent of fee-for-service, so they went from 95 percent to a much higher rate. According to a number of independent reviews of quality, the quality was not improved. It was, on average, delivering similar benefits.

What has happened with the framework put in place, again, within the Affordable Care Act, is those costs for Medicare Advantage have gradually come down, so what was at 114 percent is more like 106 percent now. Quality has improved. More seniors have chosen the 4- and 5-star quality plans, and more plans are migrating in that direction. Rates have come down. Seniors are paying about 10 percent less than they did 4 years ago.

The access is, throughout the country, 99.1 percent of seniors have many choices for Medicare Advantage plans. Ninety percent of them have access to a zero-percent Medicare Advantage plan. So what we have seen is more competition, more plans, lower costs.

Frankly, all seniors benefit. Thirty percent choose Medicare Advantage plans. The 70 percent who do not choose Medicare Advantage plans were subsidizing those higher costs through their premiums. That has, again, decreased, and the seniors who choose Medicare Advantage plans are no longer paying $1,280 more than their colleagues who were choosing traditional Medicare.

The CHAIRMAN. Thank you.

Senator Hatch will go next. Senator Rockefeller will be here by 10:40, colleagues, and we are just going to keep this going through the vote so that everybody is going to get a chance to ask their questions.

Senator Hatch?

Senator HATCH. Well, Madam Secretary, today the administration has made at least 20 unilateral changes to Obamacare without consulting Congress. The most recent was the announcement on March 31st, the enrollment deadline, that the enrollment deadline would be delayed for those who merely claimed to have technical difficulties signing up.

On March 12th, you testified before the House Ways and Means Committee and were asked by Representative Kevin Brady, "Are you going to delay the open enrollment beyond March 31st?" Your response was, "No, sir." Barely 2 weeks later on March 26th, you announced that the March 31st deadline would be indefinitely delayed. So, clearly there is some disconnect on this point, so let me ask you two questions.

One, will there be any more unilateral changes or delays to any part of Obamacare? "Yes," "no," "I do not know" are all acceptable answers here, but I need a very clear response from you on this one. Two, if you do expect more changes or delays to Obamacare, what exactly might they be, or will they be?

Secretary SEBELIUS. Well, Senator, I need to start my answer with clarifying what you have already stated. We did not extend the open enrollment period. What we said was that people who were in the system, who were trying to get enrolled by the 31st, could finish the process.

I believe in customer-friendly operations. What we had was 2 million visits over the weekend and 380,000 calls to the call center, and then on Monday the 31st we had 4.8 million visits to the website and 2 million calls. A number of people were given the op-

portunity to return to the site, giving their e-mail and their call number, and they are doing that. The site has said very clearly from midnight on the 31st that open enrollment is closed.

We also have some paper applications which are being processed. States are processing applications. But we did not extend the open enrollment period beyond the 31st. We are giving people a chance to finish their purchase.

We do not anticipate at this point, Senator, additional delays. Most of the policy issues are out. What we have tried to do over the course of the 4 years of implementation is do a gradual transition into a new marketplace strategy and, as we issue rules and regulations, make them work for people as much as can possibly be done. We will continue to do that, but I think the basic policies are now in place, and we anticipate moving forward.

Senator HATCH. All right. As I mentioned in my opening statement, a conservative estimate of how much the administration has spent to date on efforts relating to enrollment total over $1.3 billion. These amounts are in addition to the millions spent by Enroll America and others that you yourself helped to raise.

Now, I see that, in your fiscal year 2015 budget, you have requested an additional $774 million for consumer information and outreach. By my calculation, that adds up to over $2 billion that we spent in a little over 2 years. As of now, HHS has reported that 7.1 million people have enrolled in private coverage.

Now, these are enormous sums of money to be paying for such a small fraction of the population, especially considering that preliminary estimates show that well over half of these enrollees already had health insurance before the law went into effect and that most of them will also obtain advanced premium tax credits, which further drives up the cost to taxpayers.

Now, given that you propose to spend more than $2 billion in outreach and enrollment, let me ask two questions of you today. One, can you tell us today how many of the 7.1 million enrollees the President has touted already had health insurance before the Affordable Care Act went into effect and how many were forced to give up their insurance due to mandates under the law? "Yes" or "no"?

Secretary SEBELIUS. I do not know what I am saying "yes" or "no" to. You asked a question about how——

Senator HATCH. Well, how many of those 7.1 million enrollees that the President has mentioned have had health insurance before the Affordable Care Act went into effect? How many were forced to give up their insurance due to mandates under the law? Were there any forced to give up——

Secretary SEBELIUS. Senator, there were a lot of plans that were adjusted to come into compliance with the law, and there were certainly people who were transitioned into new plans and given options of new plans. I do not have data to give you right now in terms of who exactly was previously uninsured. We are collecting that.

The recent independent Rand study that just came out this week says that, before even the final surge at the end of March, by mid-March, there were an additional 9.3 million people with health insurance thanks to the Affordable Care Act.

I can tell you that those numbers are going to be much more significant by the time we tally the newcomers. But the insurance companies are presenting us with that data, and we will continue to collect that and give it to you as fast as we get it.

Senator HATCH. All right. If you do not have these numbers today, I might understand that. I just really need to know when you are going to make them available. Do you think——

Secretary SEBELIUS. Well, again, Senator, over 2 million people have signed up since the 15th of March. We are getting that information from insurers. We do not have individual names and numbers of who exactly was insured prior and who was not, so we will be feeding you information as soon as we get it from the companies.

Senator HATCH. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch.

Senator Stabenow will talk, and I am going to run and vote and hopefully be back. Senator Rockefeller is on his way, so, colleagues, we will just go back and forth. There are 5 minutes left in this vote.

Senator Stabenow?

Senator STABENOW. Thank you very much, Mr. Chairman. Welcome, Madam Secretary.

The ongoing debate on health care reminds me very much of the old saying, it is a lot easier to tear down a house than to build one. I remember under Medicare Part D, I voted "no" because I did not support the structure. I did not shut down the government afterwards because I did not get the approach on Medicare Part D that I wanted.

We are at a point now where we need to be talking about how we move forward and strengthen and make better something that, as you have indicated, 7.5 million people are now using to get their health insurance, many for the first time, for themselves and their families. It does not count the 3 million young people on their parents' insurance under age 26, and it does not count the millions under Medicaid.

I have a question, but first just a comment in comparing differences in values between the President's budget, the Affordable Care Act, and the Ryan budget that the House will be voting on.

I think it is stark when we look at, under Medicare alone, in addition to costs going down, as you have said, we have seniors with about $1,200 more back in their pocket because we closed the gap in Medicare Part D. That was one of the things we needed to fix after we passed that, and we did fix it. Chairman Ryan's budget, the Republican budget in the House, would block-grant Medicare, turn it into a voucher, and tell folks to go back and figure it out with private insurance companies. A big difference.

The Affordable Care Act—we are looking, in Michigan alone, at upwards of 400,000 people who have never had insurance before, a lot of those working minimum-wage jobs, 40-hours a week, minimum-wage jobs, still in poverty, getting care and being able to get health insurance.

In the House budget, they will block-grant Medicaid and cut it by $732 billion over 10 years, a big difference in values and views.

If I understand right, the majority of those on Medicaid, in terms of the costs, are seniors in nursing homes, so this is a huge cut there.

Finally, I would just say that the Affordable Care Act—7.5 million people being able to get health care for themselves and their children, many for the first time—the Ryan budget repeals that and basically takes that back to zero and puts the health insurance companies in charge of whether or not they drop you for a preexisting condition. So a big difference. I hope that we are going to really debate how to move forward rather than move backwards to that system.

I have a couple of questions on two different topics, actually. I talked to you a little bit before about a real victory for community mental health that we were able to achieve with support from the committee on a bipartisan basis in the Medicare, as we call it, Doc Fix bill.

We now have a demonstration project that will be taking place, rules that need to be written, and I just want to make sure that HHS and CMS and SAMHSA, who will be charged with drafting the regulations, will work with us, Senator Blunt and I and others who care deeply about moving this forward as quickly as possible, so that the States can apply for these demonstration projects and we can strengthen community mental health care. So I would like to have you comment on that.

Secretary SEBELIUS. Well, Senator, first of all, I want to thank you for your leadership in this area. You and I have worked on this for a while. I think this is a big step forward to find out how we can structure programs and actually develop some best practices that could be used then to take it to scale.

So we look forward to working with you, Senator Blunt, and others to fashion the rules and regulations, to get the Requests for Proposals out the door quickly, and to actually get those best practices from States around the country to figure out how to make sure that the mental health system, which is in definite need of assistance, really is grown and fostered in various regions of the country.

Senator STABENOW. Right. Thank you.

Another area that is critically important, if we want to talk about cost as well as saving lives and supporting families, is the area of Alzheimer's. I wonder if you might speak for a moment about the President's budget. We have had the Alzheimer's Association in town, and I met with people, again, as I have in the past, from Michigan.

We all are touched by this issue, and, as we grow old and have a chance to live longer, it becomes more and more of an issue. One in five Medicare dollars is spent on someone with Alzheimer's, and that does not count the caregiver responsibilities and challenges to the families.

Despite the shocking cost to the health care system, only .25 percent is spent on research. So I wonder if you would speak to this and how we might work together to really focus in on research and caregiving support for those with Alzheimer's.

Secretary SEBELIUS. Well, Senator, the Alzheimer's Action Plan, which was put together with a lot of stakeholder input, has a num-

ber of features in it. Certainly, research is at the heart of it. I think that the NIH proposal for brain mapping will have a significant impact on Alzheimer's. Trying to identify exactly what is going on at what stage would be helpful to try to identify people who may be prone to being diagnosed with Alzheimer's and whether or not there are any effective strategies for real recession, much less cure.

I think that there is an increase and a variety of ways in not only the brain mapping strategy, but NIH is proposing to spend an additional $63 million to continue to implement the components of the national plan to address Alzheimer's disease that was put in place and has a scheduled spending plan up until 2025.

A total of $2.8 billion is in our budget for 2015 on Alzheimer's disease, which is an increase. Some of that is for caregivers and hospice. That is run under the umbrella of the Administration for Community Living. Some of it is within NIH. There are other strategies in place. So, we share the concern that this is a growing issue. As seniors live longer, frankly, we are going to have significantly more diagnoses along the way. So I think both the President's budget calls this out, and certainly NIH has identified this as a key concern moving into the future.

Senator STABENOW. Thank you very much.

I turn it now to Senator Enzi.

Senator ENZI. Thank you, Madam Chairman.

Secretary Sebelius, I appreciate you being here today. I see that a new health care workforce program is promoted in your budget, like the expansion of the National Health Service Corps, which is $4 billion in new funding, and then the new targeted support for graduate medical education. They are included under the purview of the Health Resources and Services Administration. However, according to recent GAO analyses of Federal health care workforce programs, there are already over 90 programs in the Federal Government, including more than 50 within HHS, dedicated to improving the health care workforce.

Did the Department assess whether or not the proposals for new programs would be duplicative of existing efforts before including them in the budget and, if not, why not? Are there programs that should be reduced or eliminated as a result of the proposed expansion of the Health Service Corps or the new funding for the graduate medical education?

Secretary SEBELIUS. Well, Senator, we definitely did an analysis and looked across the Department. Frankly, the bulk of the workforce training efforts are in the Health Resources Services Administration, which is why we are proposing that the additional effort also be designed and promoted by HRSA. HRSA also is the umbrella agency over the Community Health Centers, where a lot of the National Health Service Corps members end up practicing, so it was a logical combination.

What we are doing is, I would say we are not decreasing funds in some of the earlier programs, so we are certainly targeting those funds. The focus of a lot of the workforce goals is focusing on more physicians to work in primary care and under-staffed specialty areas.

Senator ENZI. Well, I appreciate what they are aimed at doing. Did you find anything duplicative that you are going to eliminate that would help us out in this budget situation?

Secretary SEBELIUS. Well, again, I do not think it is necessarily duplicative; it is shifting. What we have been doing for a couple of years, for instance, is changing some of the research slots, the residency slots, to focus on primary care, collecting them, if you will, from institutions that were not doing that and refocusing them.

So it is not that they have been eliminated, because I think everyone would agree that, with the population that we have and the health needs that we have, we are going to need more providers, not fewer providers. So we have not eliminated anyone, but I would say we are much more strategic about the way money is being spent.

Senator ENZI. So we will have 92 programs instead of 90.

The administration announced that it was going to begin open enrollment for the exchanges for the 2015 plan year on November 15, 2014. Conveniently, that date falls after the election day this year and is over a month later than the traditional beginning of open enrollment season for health insurance plans, including the exchange.

Can you explain why the administration elected to begin the enrollment so late in 2014, and can you assure the committee that this decision was based on input from insurers, consumers, and other stakeholders, and not simply made to provide political cover for vulnerable members?

Secretary SEBELIUS. Yes, sir. I think that the date was very much in collaboration with the insurers, looking at their calendar. Frankly, you cannot bid on the new plans until you know who is in their pool. Given the fact that that pool is currently being tallied, this is a multi-month process where they will then be able to assess who is in, what their pool looks like, and be able to compete and offer bids for the following year.

There is no traditional open enrollment. This will be the second year. We had a 6-month open enrollment the first time. We always knew that the second time around and in subsequent years we would have a shorter open enrollment, so choosing a portion of that window to move forward is exactly what we have done.

Senator ENZI. Thank you. Thank you.

A number of my colleagues and I sent a series of letters to OMB expressing significant concerns with the administration's treatment of certain self-insured plans under the rules for the reinsurance program. Specifically, we were concerned that the administration would exempt certain insurance plans from paying the reinsurance fee.

Many of them were union-sponsored plans, which would create the appearance of political favoritism. Sure enough, the administration has done just that. Can you please explain why the administration believed it was necessary to exempt those plans from paying the fees and not others?

Secretary SEBELIUS. Well, the policy decision was that plans that are administering their own insurance going forward, and do not rely on an insurer, were not covered by the reinsurance fee. There are some union plans that are in that. There are a whole lot of self-

funded employer plans that are also included, and that was just a policy decision that was possible under the law. We got a lot of input from stakeholders along the way and made that call.

Senator ENZI. Thank you. My time has expired.

Senator ROCKEFELLER. Who is up? Is it Cardin? Senator Roberts.

Senator ROBERTS. Mr. Chairman, I am going to yield my time to Mr. Grassley, who has a very important commitment.

Senator ROCKEFELLER. Did he tell you that specifically with any detail? [Laughter.]

Senator ROBERTS. Something about ethanol. [Laughter.]

Ethanol and pork producers, I think were the two top things. But I may be mistaken. Anytime the distinguished Senator says he has a very important commitment and could I yield, I would be more than happy to do so.

Senator GRASSLEY. Thank you.

Senator ROBERTS. And I hope you will recognize me later.

Senator ROCKEFELLER. Yes, I certainly will.

Senator GRASSLEY. Can my 5 minutes start over again, or do I—— [Laughter.]

Senator ROCKEFELLER. Yes. You have 5 minutes.

Senator GRASSLEY. There are two things I would like to discuss with you. One is sunshine, and the other one is kind of an obscure part of Obamacare, but something I have brought up with you before.

So I welcome you, and I am glad to have you here, because I wish we could see you more often. Yesterday, your department began the process of releasing Medicare payment data. This is something Chairman Wyden has already spoken about, but he and I have been working on that for years.

No one should be—this is before I get to your question. No one should be afraid of this data coming out. No one should be afraid of explaining their payments or defending the existing payment structure. Certainly we in Congress benefit from asking tough questions about the data and considering policy changes as needed. I believe transparency works, and with transparency you get accountability. I hope people will now accept that and work to improve the system instead of fighting it. But context is critical.

So now I want to bring up the Physician Payments Sunshine Act. That kind of fits in. It is also a form of payment transparency. I remain concerned that the database collected by CGI will provide appropriate context. Many providers have raised concerns with me about journal article reprints being reportable. I want to know if the database will make clear to the readers what specifically a provider accepts is reportable.

So I would like to have you tell me that providers can have confidence that the data made publicly available through the Sunshine Act will have explicit context providing details about items accepted and not just dollar amounts.

Secretary SEBELIUS. Well, Senator, I am not sure I can answer that specifically. I will definitely check on that. As you know, we are doing the data collection. We are on track to have publication this fall. We are doing the data collection—first aggregate data and then secondly with more granularity. We believe like you do, that transparency is very important. But I will double-check on what

exactly will be part of the display when it is out. I agree with you that people should be able to put it in context.

Senator GRASSLEY. I wonder if, before you answer us, you could have somebody on your staff talk to my staff——

Secretary SEBELIUS. Sure.

Senator GRASSLEY [continuing]. So we get some idea where you are headed, so, if we think you are not headed in the right direction—I am not saying that you are responsible to us, but we want to make sure this Sunshine Act works.

Secretary SEBELIUS. Well, I know your leadership, Senator, along with Senator Kohl and others, on this Sunshine Act was critical. We share your concerns. So we would be happy to come in and do a briefing on exactly what is being collected now and what the second phase looks like, because the worst of all worlds is to put data out that is inaccurate or interpreted inaccurately.

Senator GRASSLEY. Sure. Yes. I do not think it would be inaccurate.

Secretary SEBELIUS. Yes.

Senator GRASSLEY. But I think the latter part of what you said is possible.

Secretary SEBELIUS. Yes. Right.

Senator GRASSLEY. Now to this next issue. I think I have discussed it with you before in this context, or maybe written you a letter or something. I would like to turn to the Anti-Kickback Statute and its application to qualified health plans under the Affordable Care Act.

I have three questions that I hope you can give me a short answer to, and they are kind of hypothetical. Would a hospital or other third party be allowed to pay insurance premiums for individuals without payment being considered a kick-back? Well, let me ask two other hypotheticals. When I say "hypothetical," it seems to me like these are things that could actually happen.

Would a hospital or other third party be allowed to pay insurance co-pays and deductibles without the payments being considered a kick-back? Or a third example: can a drug company provide direct discounts to a patient for them to use in purchasing prescriptions without the payment being considered a kick-back? That is the end of my questions on that subject.

Secretary SEBELIUS. Senator, I do not want to try to give a legal answer, because I am not a lawyer, to those three very specific questions. I can tell you we have made some guidance available so, for instance, not-for-profit plans, a Ryan White plan, could help purchase insurance coverage. That has gone on for years. That would continue to go on.

In terms of the hospital situation, we have weighed in and said they would not be able to do that, but the kick-back determination really is a Justice determination. The reason we, I would tell you, interpreted that the Federal health care program applicability is not able to be applied to the qualified health plans is that these are private insurance plans operating in a private market with customers paying their premiums, not connected to the trust fund like Medicare Advantage, not connected to a government program. So it was a determination that we wanted to make clear, that this was a private market.

Having said that, we know that it is important that we look at the entire fraud statute. They are not immune from that in any way, shape, or form and have in fact asked our Inspector General and others to look at the False Claims Act and other applicable statutes so we make sure that we hold them equally accountable.

Senator GRASSLEY. Mr. Chairman, can I have just 10 seconds for a summation, not a question?

The CHAIRMAN. Sure.

Senator GRASSLEY. I want to say to you, Madam Secretary, that with the release of the rule regarding qualified health plans in the anti-kickback statute, it is very unclear to me what the Federal policy is regarding the anti-fraud provisions available in statute and whether they would prevent false claims and kick-backs for qualified health plans. So this is something that probably I hope I can continue to have a discussion with you on. Thank you.

Secretary SEBELIUS. I look forward to that.

The CHAIRMAN. Let us do this, colleagues. I think we have clear sailing on the floor, so what we can do is just get every Senator who is here their 5 minutes.

Senator Thune is next.

Senator THUNE. Thank you, Mr. Chairman.

Madam Secretary, not too long ago HHS finalized a rule—and I think Senator Enzi touched on this a little bit, but I want to just get you on the record on this—that will exempt certain self-insured, self-administered plans from paying the reinsurance tax in 2015 and 2016, which, as it turns out, means that there are going to be a number of union groups that will not have to pay the tax, which would appear on the surface to be sort of a political favor.

As you know, that tax is designed to raise $8 billion in 2015 and $5 billion in 2016. There was a question posed of an HHS official recently in which that person, when asked for clarification on how the change would affect other plans, rates, and fees, said it is true that fees will be higher for plans that do have to pay the fee in 2015 because some plans are exempt.

I am wondering if you agree with that statement that those plans that did not get an exemption are going to have to pay a higher fee because the White House—I guess you could say, favored groups got a favor.

Secretary SEBELIUS. Well, Senator, I would say that what we did was look at the statutory language and made a determination that the best interpretation of the statute was that any plan that did not have an insurance component or use a third party administrator should be exempted. Our legal counsel felt that was by far the best interpretation of the statute. This was not a union issue; it was a broad-based issue about self-funded employer plans also. In order to put out the rule, we determined who would be applicable and who would not be applicable under the rule.

Senator THUNE. The question, though, is a very straightforward one. I mean, we can dispute——

Secretary SEBELIUS. Well, there is a dollar amount in the statute——

Senator THUNE. Right.

Secretary SEBELIUS [continuing]. That will be collected from those to whom the law applies.

Senator THUNE. Right. Correct. Meaning that those who did not get exempted will pay higher fees.

Secretary SEBELIUS. Well, there have never been any higher or lower. There were no fees; it was just a definition of who the pool is, who is obligated to pay the fees.

Senator THUNE. But, if you distribute that among a certain number of people, and that number of people has now shrunk because of the exemption, is it not true that those who are left in are going to have to pay more?

Secretary SEBELIUS. They will pay the fee as obligated. But again, there was no interpretation of who was in and who was out. We put out guidance, and that is who will pay the fee.

Senator THUNE. That is a very straightforward question that could result in a very simple answer. I think the answer is "yes."

I want to ask a question about the 340B program. This last year, Congress has engaged in more active oversight of the 340B program. I think that all the parties that are engaged in that program want to see it improved and maintained, that there is integrity in the program. It is vital to ensure that that program can continue to benefit the covered entities, as well as, ultimately, patients.

To that end, the Consolidated Appropriations Act provided an additional $6 million in funding to implement new program and integrity efforts in that program. I am wondering how these funds are being used. Can you provide information about HRSA's intentions to use the additional appropriations funding? An example of that, I guess: HHS has already undertaken audits of covered entities. Are there plans to extend those to manufacturers as well?

Secretary SEBELIUS. Well, Senator, I would say that Dr. Wakefield, who is the head of HRSA and the umbrella agency under the 340B program, is very much engaged in making sure that the program operates in a more stringent fashion to adhere to the rules. There are audits, as you say, already under way.

She has done a couple of briefings for me, and she looks forward to working with Congress to make sure that we are not allocating funds inappropriately and that the programs entitled to receive the 340B discounts are the ones in fact receiving the 340B discounts. So that landscape is being reviewed right now.

I cannot tell you specifically about manufacturers, but I would be glad to follow up with Dr. Wakefield and come back to you on that. I think it is safe to say it has expanded beyond its bounds, and we look forward to the opportunity to make sure that we are following the rules, because it is a vitally important program.

Senator THUNE. It is.

Very quickly, CMS's 96-hour rule regarding patient reimbursement at critical access hospitals—can you comment on that? There are a lot of physicians whom we deal with in a State like ours, where we have a lot of critical access hospitals, who do not think it is fair to impose that kind of a requirement and require essentially physicians to predict the future.

Secretary SEBELIUS. Well, I would say, Senator, this is one issue that we are getting a lot of feedback about and having a lot of conversations on. I do come out of a rural State. I absolutely know the vital health care needs that people have and how important it is

to have critical access hospitals operate in a profitable manner and stay in the community.

So I think the rule was put in place in terms of trying to define an appropriate boundary. But Jon Blum is having ongoing conversations about whether or not that may be too stringent or too rigid, so we would appreciate your input and feedback as we look toward the future.

I do not think the intent from anybody is to damage the opportunity for critical access hospitals to remain in place, but trying to define what is appropriate in terms of a patient's stay, I think, was the attempt.

Senator THUNE. All right. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Thune, I just want to let you know, I am very sympathetic to what you are talking about and am interested in working with you. It is evident that the administration will work with us as well.

Next in order of appearance would be Senator Isakson, and he, as so many Senators are doing this morning, is juggling. Senator Isakson, would you like to go next now?

Senator ISAKSON. Thank you.

Madam Secretary, thank you very much for your appearance today.

As a former Governor of Kansas, I have a question for you. It is not a loaded question; it is a question of great concern around the country in various States. In the Affordable Care Act, there is an opportunity for States to expand Medicaid eligibility. In that, there is a promise for the Feds to hold harmless the States for a period of time, but not forever.

In 1978 in the Carter administration, when we passed IDEA for handicapped children, there was a 40-percent Federal mandate of increased money flowing to under-privileged children and disabled children, with a promise that the Feds would fund their fair share. But in all the years since 1978, the Feds have not, and the cost of education in the States has gone a lot higher.

As a former Governor, do you fear at the end of the hold harmless period on the Medicaid expansion, that States that have taken it will be burned with an amount of money they cannot afford to pay on Medicaid?

Secretary SEBELIUS. Well, I certainly was the recipient of the IDEA promise that was never fulfilled, so I watched that very carefully. I could tell you that at least for the decade that ACA is funded and in place, the funds are there to, in fact, fully expand Medicaid for all the States, which is what was anticipated when the law was passed.

I do not know the window beyond that 10 years, but I can tell you that that funding is there. It is part of the law. So, unless pieces of that funding are repealed along the way or Congress decides to change the law, that will be done.

Senator ISAKSON. A second question. I was one of eight Republicans who met for a series of 8 weeks with Denis McDonough and on two occasions with the President in an ad hoc fashion, if you will, to try to find some common ground on deficit and debt reduc-

tion. This was last year, dealing with last year's recommendations by the President.

In his recommendations were significant cuts in terms of Medicare to help reduce the growth rate of the debt and the deficit. One of those was chained CPI, which at the time in the budget last year was included by the President, which has not been included this year.

Does that indicate a reduction in the interest of the administration to find ways to reform entitlements so, without cutting people's ability to get those entitlements, we manage them on a basis that makes sense for the future?

Secretary SEBELIUS. Senator, I would say that the President still is very interested in the possibility of some global approach to deficit reduction and revenue enhancement, but he has said, I think from the very beginning—and I assume he said it inside the room where you were—that he feels a balanced approach is very important.

I think there are a whole series of ideas that he put forward as part of that balanced approach, where in some cases cuts are made and in other cases revenue is raised. But in that context, which did not go forward, as we know, I do not think it is a lack of interest. He would be eager to engage in that discussion again but not make cuts where there is not a balanced approach.

Senator ISAKSON. Well, the actuarial clock is ticking on our country in terms of debt and deficit, and all of us in both parties are going to have to sit around a table and talk about some very difficult discussions. One of those is going to have to be reforms to entitlements.

I personally think calling Social Security and Medicare an entitlement is a little bit wrong, because I have paid 1.35 percent of my income for Medicare since 1968 and 6.2 percent of my income for FICA taxes for Social Security. People should expect them, but, if we continue to promise more than we can deliver and do not reform the system, one day the game is going to be up and the American people are going to be left holding the bag, and I do not want to be a part of that.

And your department has probably more to do with the rate of growth—not because of anything you are doing but just because of the demands of health care in Medicare and Medicaid—of debt and deficit of any other single entity whatsoever. So I look forward to working together with you and the administration in the years ahead to try to find some way to find common ground so we can begin to do that.

Secretary SEBELIUS. Well, I would very much look forward to that opportunity. Circling back to Chairman Wyden's point at the beginning of this discussion, I think that there was an enormous amount of entitlement reform in the Affordable Care Act around Medicare, and it is working.

It is working in a way that was difficult to predict at that point, but it is happening. I think that it is continuing on into the future. I think the recent prediction of the actuary—if we could just keep Medicare spending at the rate that we have seen the last couple of years, we would have an enormous change in the overall cost growth.

So I think there are some features in place, some ways to shift from a volume payment to a value payment, some different reforms, as the chairman referred to, the delivery system reforms that are beginning to show very promising results. So I think that we would very much look forward to talking about a structural change that really is on the delivery system payment side and keeps benefits in place for seniors.

Senator ISAKSON. Well, I agree with that comment. I just do not want us to substitute provider cuts for reform. We can reach the point where you can cut too far, and then it is not reform, it is disastrous for the program.

Thank you very much.

Secretary SEBELIUS. Yes. Thank you, sir.

The CHAIRMAN. And, Madam Secretary, I would just say, we talked about chronic disease earlier. Senator Isakson and Senator Toomey on that side of the aisle, Senator Warner, and others have a great interest in working with you on that, and we want to follow up there after the hearing.

Senator Cardin is next.

Senator CARDIN. Thank you, Mr. Chairman. Secretary Sebelius, thank you very much.

Let me just make one comment about the Affordable Care Act. We now know millions of people who have directly benefitted from the Affordable Care Act, from the Medicaid expansion that you talked about, which has been a great success in my State, to the insurance reforms that have protected families, to Medicare filling in a lot of the coverage gaps that we had for preventive care and prescription drugs, to now people having affordable options through the exchange to get quality insurance products.

I just want to make one observation. It would be, I think, a lot easier for you if we in Congress took a look at the law as to how we could help you in dealing with many of the challenges that you have had in implementing the law, but instead we are still stuck in this repeal/non-repeal mode, particularly in the House of Representatives.

That is not doing a service to the people of this country, because we should be working together to give you the budget support that you need and to take up the law as to what we need to do to improve it, make it stronger, and make it easier for the American people. I hope that as we talk about a bipartisan budget, for my friend Senator Isakson, whom I admire greatly, that we also talk about working together to make our health care system work in this country. I think the framework of the Affordable Care Act is proven to millions of Americans, and I can give you many, many letters that I have received from people whose lives have been changed because they now have quality insurance coverage.

On the budget, and I think we are here on the budget, I will start with a "thank you." That is, the Holocaust survivor assistance that is in this budget for the first time will provide direct help to Holocaust survivors, Americans who are very vulnerable, with a real fear of institutionalization and getting help to access governmental services, and I thank you for including that in the budget.

On the other side, the realities of the budget hit home, I think, with the National Institutes of Health. The budget there, to me, is

entirely too low. I am extremely disappointed that several of the Institutes get no increase in their budget at all, including the National Institute on Minority Health and Health Disparities that you and I have talked about in the past.

I know your commitment to that Institute and to the departments and agencies that are directly responsible for dealing with minority health and health disparities. I just encourage you to do everything you can within the budget restraints to continue to make that a top priority.

Let me ask a question as it relates to the therapy caps in the SGR. I am strongly in support of Chairman Wyden's and Senator Hatch's efforts to get a permanent fix, a replacement, to the SGR and the therapy caps and the other issues. To me, that makes the most sense. We are very close, and I hope that we can continue to work on it.

But in the meantime, we are still in that mode of dealing with a temporary extension through March of next year. In the therapy caps, which make absolutely no sense whatsoever from a point of view of health policy, we now have the manual medical review issue on those that hit the cap at $3,700 that could prevent access to timely payment.

It is my understanding that you are considering some payment review rather than looking at it and holding up those who are in need of care, wondering whether their services will be covered or not. Can you just give us an update as to the implementation of the therapy cap under the existing law, how you envision that during this period of time?

Secretary SEBELIUS. Senator, what I would like to do is come back to you with a much more descriptive answer of what our folks are looking at for, as you say, what may be this interim period of time. I know there has been a lot of discussion.

I do not want to give you incorrect information about the direction that is likely to go, but I do know it is of great concern in terms of patient care and how it is interpreted, so I will circle right back and give you kind of an updated answer from our Medicare team on how they anticipate going forward.

Senator CARDIN. Thank you. I yield back.

The CHAIRMAN. Thank you, Senator Cardin.

Senator Roberts is next.

Senator ROBERTS. Well, thank you, Mr. Chairman.

Madam Secretary, I have a couple of news articles here that maybe you could help us clarify as to exactly what is going on. Rather than me trying to explain this, I am just going to read it.

"Americans thinking about buying health insurance on their own later this year or maybe switching to a different insurer are probably out of luck. The policies are going off the market as a little-noticed consequence of the Affordable Care Act. With limited exceptions, insurance companies have stopped selling until next year the sorts of individual plans that used to be available all year round. That locks out many of the young and healthy, as well as the sick and injured, even those who can afford to buy without the government subsidy. Now they are stuck, according to an independent insurance broker in Los Angeles, who says she warned her customers last year the change was coming. It just closes everything down.

The next wide-open chance to sign up comes in November when enrollment for 2015 begins. Companies are following that schedule even for the plans they sell outside the Federal/State exchanges."

There are other news articles that say the same thing, and I am not going to take the committee's time to read them.

Could you clarify that, because I think there has probably been some misunderstanding, or perhaps you can shed some light on that.

Secretary SEBELIUS. Certainly, Senator. As a recovering insurance commissioner, I would tell you that the rules that you just described are really set at the State level. You quoted an article from Los Angeles, and they have decided in California that they will not allow off-market plans to be sold. They want to encourage people to buy during open enrollment inside Covered California. This is a State-by-State decision.

I think Kansas has made a very different decision. So those determinations about what the off-market plans will be and how robust that market will be are made by individual insurance commissioners throughout the country.

Senator ROBERTS. Well, we have an expert at the Kaiser Family Foundation, and he says it is highly unlikely—he is talking about nationwide now, not just State-by-State—that companies will offer such coverage after the deadline window fully closes.

Some still offer temporary plans lasting from a month to a year, but those plans do not cover pre-existing conditions, do not get buyers off the hook for the law's tax penalty, and there is a window for life-threatening situations.

I know you are stating that is up to individual States and their insurance companies and they are all different, but I think that this is a national concern. Am I wrong on this? Help me out here.

Secretary SEBELIUS. Well, again, it is my understanding that it is very different State to State, that a lot of States will have robust off-market plans that will actually have a number of the consumer protections and features that are in the market.

But it is a State-by-State decision. I think that reference, Senator, may be to the accepted plans, the kind of mini-coverage plans, and those will be less available. But again, the companies are making that determination, not the law.

Senator ROBERTS. Well, I think the companies are making the decision due to the law, but we will get past that.

I want to go back to the 96-hour rule, because it gets to the President's budget, which is the same question that I asked you last year about the proposals included in the budget that caused disruption to the critical access hospital delivery. You are extremely familiar with that, in that you designated some of these hospitals in Kansas.

So I am concerned that the proposals are once again in the President's budget. They set the mileage limits and they reduced the reimbursement for critical access hospitals. We all know the value of the critical access hospitals. We have 83 in Kansas, as you know.

I would like to know if we could get some regulatory relief. In that regard, one of the more problematic decisions is based on a letter that I wrote, if I can find it. But at any rate, it was to CMS

and indicated that—here it is. And the reply was that they are "statutorily obligated to enforce the new requirements."

I do not know where we came up with 96 hours. I mean, you could do 120, 72, 48 hours, whatever. Then, if you have a patient come in to that hospital, they can keep them for those number of hours, and it seems to me that it was not statutorily designated. When I asked if they could waive that in certain conditions or be of help, they said, well no, it was statutory. It is not. That is just, once again, something that we could do.

Could we get 1 year's relief from that? I understand you said that Mr. Blum, or maybe Marilyn Tavenner, could be of help on this. What happens is, the patient comes in, they are monitoring that patient, and then these hours go off. The doctor does not get any Medicare reimbursement so they would have to go to another hospital which could be miles and miles away, or just out of the hospital. You know about hospital readmissions; you cannot do that. Help me out on that.

Secretary SEBELIUS. Well, Senator, what I would like to do is maybe get a copy of the letter that you are referring to, and I will personally follow up with Marilyn Tavenner and Jon Blum and get back to you. I do not know exactly what the questions were in the letter, and I do not know exactly what statute they were referring to, but I will definitely circle back and get you a response.

Senator ROBERTS. I appreciate that.

Secretary SEBELIUS. I agree that we do not want to make it more difficult for patients to access care or for doctors to be reimbursed.

Senator ROBERTS. I appreciate that. I will provide the letter as soon as possible.

Secretary SEBELIUS. Thank you.

The CHAIRMAN. Thank you, Senator Roberts.

Senator Casey is next.

Senator CASEY. Thank you, Mr. Chairman.

Madam Secretary, thank you for your testimony and for your service. I was not here during your testimony regarding the number of folks who have taken advantage of the exchanges, and I guess we are up to 7.5 million. That is good news.

I wanted to ask you about two questions, the first regarding children. On the one hand, I cannot say enough about the commitment the administration has made to our children on a whole host of fronts—a very substantial commitment on programs and on prioritization. I commend you for that, and I commend the President.

Where I have kind of a fundamental disagreement with the administration, and where I think we will probably continue to be—and I hope not—unalterably opposed to the administration's policy as it relates to children, is graduate medical education. We fortunately passed, and the President signed into law, a bipartisan reauthorization. I was very happy about that. We have worked very hard on that.

But I know going forward that the position of the administration is to eliminate that funding for that program. I do not agree with that, and I wanted to ask you about it. We have right now about 1 percent of all hospitals train nearly half, about 49 percent, of all pediatricians.

So you have a program that works. It delivers tremendous results. It solved a big problem, meaning pediatric care, or the shortage of that if we did not have the trained specialists. It is bipartisan. It is not expensive. I do not understand the opposition to it. So I would ask you about the position the administration has taken, why that is, and whether or not there is some way we can reconcile our differences.

Secretary SEBELIUS. Well, Senator, I know your commitment to this area, and, as you say, I think the administration also has a commitment to, not only children, but to training providers in needed areas. The budget proposes that there is $100 million in new, targeted support for children's hospital GME programs and additionally, with a bigger bulk of money, the $430 million, a competitive opportunity where I would suggest that I think it is possible that children's hospitals receive even a larger amount than was in the directed program of the past, because there is a floor kind of set automatically and then an opportunity for more slots.

We estimate that the new targeted support will be about 13,000 new residencies between 2015 and 2024. I will tell you that with the discretionary program in the past, about 26 percent of those slots were for non-pediatric residents. So even though it was a directed program, that is not how at least a fourth of the slots were filled throughout the hospital.

So we would love to work with you on ways to make sure that the financing that is going in is really directed to training more pediatricians, training more child specialists. I think, looking at this, there is an opportunity to really then target the funding.

Senator CASEY. Well, I hope we can, because we have in our State—and I can say this, I think, without contradiction—two of the best children's hospitals in the world in Philadelphia and Pittsburgh, in addition to St. Christopher's in Philly. So we have two in Philly, one in Pittsburgh. They are very happy with the program, and we are very concerned that it would not get reauthorized. So I hope we can continue to work together. I know I am short on time, and some of this we can do for the record by way of written response if we run out of time.

Medicare Advantage. I was grateful for the administration's recent determination as it relates to Medicare Advantage. We know that premiums are down 10 percent and enrollment is up, and that is good news. But there are still some concerns about the near term and the long term. I just want to ask, and you can amplify it in writing if necessary, what steps you plan to take to help the program remain as strong as possible.

The CHAIRMAN. Secretary Sebelius?

Secretary SEBELIUS. Yes?

The CHAIRMAN. If you could do that briefly and then get to Senator Casey in writing. Colleagues, if we sprint we can get everybody in before Secretary Sebelius has to leave, and that is my goal.

Senator CASEY. That is a good goal.

Secretary SEBELIUS. Why do I not get it——

The CHAIRMAN. Is that all right with the Senator? Great. Thank you so much.

Senator Warner is next.

Senator WARNER. Thank you, Mr. Chairman. Great to see you, Madam Secretary.

Let me first of all say, with the numbers you report today at 7.5 million, I hope this will start to change the nature of the debate, from some of us on our side of the aisle who do not want to change a word of the ACA to some of our friends on the other side who simply want to repeal.

I know they are not here, but I want to commend Senator Hatch and Senator Burr. I do not agree with the framework they have laid out, but they have laid out some alternatives. There are a group of us who have laid out a series of, I think, targeted changes to the ACA that I think will improve delivery. I would like, in my time, to touch on one of those.

One of the areas—I know you are aware that the Treasury Department recently finalized reporting rules that will help enforce the employer and individual mandates. We have this challenge, where Treasury does the reporting and HHS provides the subsidies, of trying to make sure they are correct amounts.

I continue to hear from a number of employers that are concerned that some of their workers who are offered employer plans might erroneously still apply through the exchange to try to get individual tax credits. What this is setting up is potentially, at the end of a year, a contentious dispute between the business and the IRS, with the IRS kind of being the referee. I think this could actually be prevented if there was more accountability on the front end between Treasury and HHS.

I think there are ways our legislation—we have eight co-sponsors at this point and would welcome others looking at this—would basically allow employers who would be willing to provide that information up front some ability to be forward-leaning rather than having this monthly reporting requirement that, for small enterprises, is going to be an enormous burden, to give them, not completely a safe haven, but by having this kind of up-front collaboration between HHS and Treasury, we might be able to remove one of the administrative burdens that quite honestly in a system does not need to be there. I do not know.

Our legislation is S. 2176. It is one of six or seven different pieces of specific legislation that we would like to advance, that hopefully will move the debate to, how do we keep what is good and fix what is wrong in ACA? I would just like to solicit your opinion—I do not know if you have had a chance to look at this—about whether you would be willing to work with us on this and other areas where we can streamline the process.

Secretary SEBELIUS. Well, I would very much like to work on streamlining the process. Anything that we can do up front that reduces confusion and certainly reduces administrative burden on businesses—we, as you know, Senator, took a number of your ideas in terms of how implementation and the administrative exchange of paperwork should work. The last thing I think the administration wants is to burden people who are already in the system providing insurance, trying to get accurate reporting. So yes, very much I would like to——

Senator WARNER. This is one area, again, where we have your shop doing the subsidies, Treasury doing the reporting require-

ments. If we could set the standards up front and provide employers a little more guidance, we could eliminate what is right now I think, for particularly small to mid-sized firms, this monthly reporting that I think will prove to be a burden.

Secretary SEBELIUS. I look forward to it.

Senator WARNER. Now let me hit two other items very quickly. One, I know Senator Stabenow has already mentioned this, but let me say "amen," as one of the co-chairs of the Alzheimer's Caucus, to trying to move forward on the National Alzheimer's Plan, making this a higher priority, thinking more creatively. I would echo what Senator Cardin has said as well about overall cuts to research.

But we all know, every one of us has family members, myself included, who have either passed from Alzheimer's or who are going through the scourge of Alzheimer's. This is a human tragedy, as well as obviously one of the fastest-growing expenses in the Medicare/Medicaid combined budgets.

Secretary SEBELIUS. Yes.

Senator WARNER. So we would urge your work on that.

The final point I just want to make in my 44 seconds, recognizing the Senator's goal to get us all through, I would commend this to my colleagues. Last Sunday, *60 Minutes* did a feature on a clinic called "The Health Wagon," which is in southwest Virginia. It was started back in the 1980s by Sister Bernie Kenny in an old VW, very close, Senator Rockefeller, to West Virginia, and she would travel around and provide medical services.

There was a certain Governor early in the decade who actually included this program in the State budget. It has now grown dramatically. She serves six counties, has nine folks, and has assisted 11,000 folks in an area that has dramatic poverty.

HRSA grants are very important in this innovative service delivery model, and I would simply commend, again, the remarkable, remarkable story that *60 Minutes* documented. I think it is a demonstration of really stretching dollars. For every dollar of Federal money, we get $100 back in health care services. That is a rate of return that, even as a venture capitalist, I would love to see. So, I commend that to you.

The CHAIRMAN. You Governors all stick together.

Senator Toomey?

Senator TOOMEY. Thank you, Mr. Chairman, and thank you, Secretary Sebelius, for joining us.

Let me just briefly echo Senator Warner's comments about Alzheimer's. I too was absent when Senator Stabenow first brought this issue up. But as you know, and I really think it bears repeating, we have made so much progress on all of the chronic diseases that threaten and take people's lives, especially in their older years—heart disease, cancer, stroke. Many of them are frequently not fatal. They can be fatal, but they are not always. They are much more treatable. We have so much better survival rates.

The glaring exception is Alzheimer's, for which we do not understand the cause. We have no treatment, we have no cure. So, as people live longer and longer, because fortunately they are no longer dying from these other diseases, increasingly they are being afflicted by Alzheimer's. So I, for one, cannot think of a more wor-

thy cause than finding the cause and cure for Alzheimer's. I appreciate your interest in this and your commitment, and I hope we will make this a very, very high priority.

I do have a technical issue that I want to raise with you. This arises—I am still trying to frankly wrap my brain around the many ways in which we have socialized the individual and small group health insurance market. We have the mandatory payments between the insurers that have to cross subsidization based on the risk parameters that the various firms have.

We have the famous belly button tax that covers the cost of paying for the high-risk patients that we have. Then of course we have the risk corridors, by which the government gets 80 percent of the upside and taxpayers get hit with 80 percent of the loss beyond certain parameters, which CMS gets to define.

What I found curious is that in the 2015 budget, my understanding is that OMB has moved the account into which and from which funding will go, depending on whether the government is making money or losing money in this joint venture, if you will. It has moved the account to a CMS general program management account, and that is an account into which other sources of funds go and from which and toward which other expenses are covered. I am wondering why that was done.

Secretary SEBELIUS. Senator, I would tell you that the CMS budget and a lot of the employees who are in administrative work dealing with the marketplace issues are also dealing with a range of other issues. There is no way that a lot of these programs are not intertwined with Medicare and Medicaid. They are implicated across the board, but why exactly that budget design is there any more than for the efficiencies of making it clear that that is what workers do——

Senator TOOMEY. All right. Well, my concern is this. Previously, including in the current fiscal year, under the budget that we are now operating under, any payments from insurers into this fund go into an account that immediately goes to the Treasury general fund and is used to reduce the size that the deficit would otherwise be.

Since it is reclassified into this more general program management fund, it remains available to CMS to spend on other things rather than to be used exclusively to diminish the deficit as it is now. I am concerned that, (A) it might be spent on other things, and (B) since this is commingled with other sources of revenue and it can be spent on other things, it could be harder for us to understand exactly what is happening here.

Secretary SEBELIUS. My experts tell me, because I did not want to give you an incorrect answer, that it can only be used for the risk corridor program.

Senator TOOMEY. But the account is a general program management account that has revenues that come from other sources, and there are expenditures that can go to other directions. So how will we be able to properly monitor this and know——

Secretary SEBELIUS. We can give you direct reporting on what is coming in and what is going out. But my understanding is, it can only be used on the risk corridor program.

Senator TOOMEY. All right.

Secretary SEBELIUS. We have user fee authorization in that umbrella authority, so we are using that, but it can only be used for the risk corridor.

Senator TOOMEY. So can you assure us that any surpluses that come into this account by virtue of the government's take on insurance companies' profits, or any taxpayer bail-outs of insurance companies that have losses, any of that will be precisely quantified, and we will be able to track that?

Secretary SEBELIUS. Yes, sir.

Senator TOOMEY. Thank you.

Thanks, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Nelson?

Senator NELSON. Madam Secretary, first of all, I want to compliment you. You have been through about one of the roughest patches that any department head could go through, and it is working, so congratulations.

Secretary SEBELIUS. Thank you.

Senator NELSON. It is working in our State as well. We are starting to see, there is beginning to be a realization, that there are a lot of young people who were included because they could be on their parents' policies. Now there is a realization of what is going on with the significant number that you enrolled in the exchanges.

In addition, people are catching on to Medicaid expansion. Now, unfortunately, in our State they took the position, nyet, no Medicaid expansion. Now they are starting to feel the heat from the Chamber of Commerce and the hospitals, and starting to realize that this means more out of ordinary Floridians' pockets, because people will still go to the emergency room uninsured.

So I want to thank you for your flexibility. What we are trying to present are some ideas for flexibility that the State of Florida could propose to you, CMS, Ms. Tavenner, and so forth. So what I have done is sent a letter to Ms. Tavenner that would entertain a new plan *if* the State were to suggest this—and I understand it has to come from the State—to allow for Medicaid expansion using inter-governmental transfers which would supply the State's 10 percent part in the 4th year, when the Feds will provide 90 percent and the States 10 percent.

Now, I thank you for setting the table for flexibility. There is, compounding on this, what is now going on in a State legislative session where the appropriators are meeting, which is the extension of the Medicaid waiver for managed care.

It is my understanding that there is a basic agreement of 1 year. Of course, if this can be done, if they can get that out now, it would be helpful to the State appropriators for the agreement to come in time for the legislature to incorporate it into their appropriations. I do not expect you to have the details on this, but do you have any comment on this?

Secretary SEBELIUS. Well, I can tell you, Senator, we are working very, very closely with the Florida team, and my understanding is that those sessions have been very productive. We are very much aware of the legislative deadline. While I would tell you that there is not any final resolution, I am confident that we are going to get

to a productive answer. But those discussions are very much under way as we speak.

Senator NELSON. On Medicare Advantage, we have had some complaints about insurance companies suddenly obliterating a whole bunch of doctors from a plan and obliterating hospitals from a plan. So the question is, the definition of "significant change."

What I would like is to call to your attention to remind CMS that when they are planning network changes that an insurer deems significant, there needs to be some communication of this fact to the poor insureds, as you and I, as colleagues, as insurance commissioners decades ago, would try to look out for——

Secretary SEBELIUS. It was not that many decades ago.

Senator NELSON. Believe it or not, it was almost 2 decades ago.

Secretary SEBELIUS. Well, that is a couple, you know. It is not—I agree with you, Senator. We were concerned when this issue arose, first, I think, in Connecticut. We are watching it very carefully. It is my understanding that we have provided some formal communication with insurers that a notification is indeed a part of their responsibility, and that we are going to be watching that a lot more closely to make sure that, if a plan institutes changes, beneficiaries can then make other choices based on that plan decision.

Senator NELSON. And of course I would have to mention, on behalf of our seniors in Florida, the special enrollment period for them, particularly if they need to make sure that they have the specialists that they want.

Secretary SEBELIUS. Yes.

Senator NELSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Nelson.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Welcome.

Secretary SEBELIUS. Thank you.

Senator ROCKEFELLER. I join very much with what has been said by several Senators, starting with Ben Cardin. It is extraordinary that we have a program here which is the first of its kind in history to have actually worked, to have actually been passed, and it is working. All they can do, those who oppose it, is to take out newspaper clippings. That was very smart when you said, well, that was from the *Los Angeles Times*.

But that is what they do. That is what they make a living out of. That is what they do on Fox News. It makes life very difficult for you. But always know that there are many of us who have been for the Affordable Care Act from the very beginning and will stay that way until it is absolutely perfect. That is just simply the way things happen in America. It is just, we are at a very bad patch in terms of getting stuff done or to be helpful to the American people right now.

I have a couple of questions, one on the Children's Health Insurance Plan. That is always my top priority. It has to be. I am worried about two things. One is that I cannot recall the President talking about it. Now, why would that be important? It probably is not important. But it becomes important because the CHIP fund-

ing runs out at a most inconvenient time. So we are funded through this year and part of next, and then it just stops.

So I have to, in the President's budget, understand if his feeling, and the feeling of HHS, is that we are talking about keeping this thing going for a period of years and years, because right now it is strange that he has not mentioned it, he has not talked about it. He has talked about so many social programs.

This is one of the most important for West Virginia and everybody—the 8 million Americans involved. So can we look forward to this being a continuing program, because it does not necessarily reflect itself in the budget because the budget is out of sync, so to speak, with other parts of the budget?

Secretary SEBELIUS. Well, Senator, I first of all know your passion in this area and also your incredible leadership. We would look forward to working with you on what the future looks like.

I would tell you that one of the great things I think that is going on for children around the country is, with the simplified Medicaid and CHIP application and with literally millions of people coming forward who may have been in the past eligible but not really enrolled, I think we are going to see more children gaining benefits than ever before—who probably should have been signed up in the first place, but they just were not because States were not taking down some of the blockades and barriers. States are now making it far easier for people to be engaged in that process. I think that is all very good news for the children of America.

Senator ROCKEFELLER. I would agree with that. But I would really be happy if the President, in one of his press conferences or something, just mentioned it. It is just odd to me, knowing him and his commitments, that he just simply has not mentioned it at all.

Secretary SEBELIUS. Well, I will share that.

Senator ROCKEFELLER. Thank you.

Secondly, black lung. Obviously that is most important for West Virginia. What you have is, HRSA has imposed a new requirement, and it is abstract, so to speak. It puts a limit of $900,000—and then it is capped—that any one State can get for that. West Virginia, last year, spent $1.4 million for a very simple reason: we have an awful lot of coal miners, and we had an awful lot more coal miners before, so the black lung back-up is huge.

There are various ways we are trying to, through the reduction of ambient air pollutants in coal mines—you cannot treat or you cannot cure black lung, but you can prevent it, but only by having a clean coal mine, which operators are loathe to do.

But nevertheless, I am stuck with this West Virginia problem. We are the only State which is affected by this HRSA initiative. As far as I am aware, we are the only State. That is not pleasing to me, because we worked very hard on it, and we have an awful lot of people, because that has been sort of our history. What I would like you to do is waive West Virginia, but somehow we need to solve this problem.

Secretary SEBELIUS. Well, Senator, it is my understanding that the HRSA cap is not for a State, it is for an entity. In fact, in many States there are multiple entities who are receiving funding for various support services. So we would like very much to work with you about what is going on.

Senator ROCKEFELLER. Well, but that raises——

Secretary SEBELIUS. I think West Virginia could get significantly additional resources, and probably should, given the level of disease in the program.

Senator ROCKEFELLER. That brings up a further thought, that one of the effects of the HRSA rules and regulations would be we would have to sort of divide black lung clinics up into different lumps. We have nine of them in the State, and what would happen administratively to black lung clinics is very untidy and unhelpful. If you could just go look at that problem.

My final point is, Senator Isakson wanted to reduce the deficit, and we all want to do that. What I am going to bring up probably has no chance of passing, because the power of the pharmaceutical companies is very, very strong on the Finance Committee, which I regret to say. But the easiest way to do that is to simply go back to what we were doing with the dual-eligibles, 9 million of them, when they were under Medicaid and it was all rebated pricing.

There was an enormous amount of money saved. The pharmaceutical companies now say, well, we would have to stop doing research and all the rest of it. But of course back then when it was in effect under Medicaid, they were doing fine. They were doing just fine, thank you.

Now all of this, the dual-eligibles, is under Medicare. We made that switch in Medicare Part D, but we did not switch the rebated pricing part. If we were to do so, we would save $141.2 billion over 10 years.

Secretary SEBELIUS. Senator, that is why we need to pass the President's budget, because that recommendation is in the budget.

Senator ROCKEFELLER. Yes. Yes. Yes.

Secretary SEBELIUS. I agree.

The CHAIRMAN. Let us do this. We are going to rush to get all Senators in. Senator Carper is next, if that is all right, Senator Rockefeller.

Senator ROCKEFELLER. Sure.

The CHAIRMAN. Senator Carper?

Senator CARPER. Thanks. Welcome, Secretary Sebelius. It is very nice to see you again. Thank you for your stalwart stewardship and leadership in these troubling, trying, but ultimately encouraging months. Thank you.

One of the things I look forward to seeing every Thursday in my clips is a report from the Department of Labor, and every Thursday we get from the Department of Labor, on Thursday morning, the number of people who filed for Unemployment Insurance the previous week.

The week that Barack Obama and Joe Biden were inaugurated as President and Vice President, that week the number of folks filing for Unemployment Insurance was 628,000 people. When I read the news today in my clips, that number for this past week, announced today, was 300,000 exactly, right on the money.

When you think about job creation in this country, any time that number is under 400,000, we are creating new jobs. What we do is, as the number bounces up and down, as you probably know, we take a 4-week running average and keep updating that. That number is running at about 320,000, and we are at a point where we

are creating significant jobs. We need an economy that creates even more.

One of the keys to doing that, according to Alan Blinder, who used to be Federal Reserve vice chairman but is back to teaching economics at Princeton—he sat right where you are sitting less than 2 years ago, and I asked him a question about deficit reduction, what we need to do.

He said the 800-pound gorilla in the room on deficit reduction, and on growing the economy, is to get our arms around and our heads around the health care costs and to be able to wrestle them to the ground so we can get essentially better results for less money.

I am encouraged when we look at the growth of health care costs as a percentage of GDP, which has gone up, up, up forever. Last year, it actually came down a little bit. Hopefully with all the smart things we are doing—not just in the Affordable Care Act but just by health care providers, companies, employers, just a lot of smart stuff, moving from a sick care system to a health care system and focusing on prevention and wellness and making better use of technologies—this is morning in America on this front.

A question, if I could. Alan Blinder said to us that morning, when I said, what do we need to do to continue to make progress on reducing health care costs as a percentage of GDP: find out what works and do more of that. I said, do you mean, find out what does not work and do less of that? He said "yes."

But in terms of finding what works—as you know, obesity and costs that relate to obesity are just eating us alive. We are trying very hard in this country to reduce not just the size of our deficit, but reduce the size of our girth and lose weight and be able to start ratcheting down those costs.

But I just want to ask, in the President's budget with respect to obesity, the need to do more there, the costs that run from that, and also medication adherence—we know that we can save a lot more money if folks actually take the medications they are supposed to take and to continue to take and so forth. Just those two points: in the budget, how do we address obesity and continue to bring it down; how do we address medication adherence and continue to improve that, please?

Secretary SEBELIUS. Well, I would say, on the first front of obesity, there are a whole variety of programs under at least our umbrella that offer support for the First Lady's entire initiatives, which actually are making a significant difference. There are the efforts to work with our partners at the Department of Education to revamp everything from school lunches to exercise programs. The new FDA rules and requirements and more are coming on nutrition facts, giving consumers the tools they need to make good choices. Menu labeling is under process and will be out shortly. Then there needs to be ongoing research on what exactly works.

In addition to the Prevention Fund, there are efforts around community projects, what really works. We know a lot about smoking; we do not know a lot about obesity, what actually is the most effective thing to get people engaged and involved and actually have them make different decisions about exercise and eating. So there

is a lot in various agencies in our budget and through the CDC that is working on the obesity front.

I would say on medication adherence, it is one of the key targets of the Partnership for Patients, which has been a very effective effort involving over 3,000 hospitals and doctors' offices. It also is a piece of what the electronic medical record effort is about, which is collecting the data.

It is stunning how many patients with high blood pressure are not monitored on a regular basis—leading to heart attacks and strokes—to see who has high cholesterol that is not being followed up on, who is actually not taking their meds.

So part of becoming a meaningful user in the electronic record world is that a provider not only has to collect data, but then demonstrate that there are actual changes being made and patients being monitored, which I think can be enormously effective, and tying pay to those quality outcomes is going to be enormously effective.

Less than a third of the people in this country diagnosed with high blood pressure are on any kind of strategy to reduce that blood pressure. And our folks feel you could save a million hearts, as they say, a million heart attacks and strokes by just collecting data, focusing on the ABCs, and making sure that a piece of that is management of chronic conditions.

Senator CARPER. Great. Thanks.

Thank you.

The CHAIRMAN. Thank you.

Senator Menendez?

Senator MENENDEZ. Madam Secretary, thank you for your service and for performing an extraordinary job under a landmark law's implementation.

One of the main goals of the Affordable Care Act was to provide access to health care coverage to all Americans, and the expansion of Medicaid eligibility was a fundamental step towards achieving that goal. I am pleased that New Jersey is among the States that expanded their program, but I am also concerned by some reports, including one in this morning's *National Journal*, about how Medicaid applications are being processed in several States, including New Jersey.

Specifically, I am hearing about extensive backlogs caused by the New Jersey Medicaid Department's need to input the applicant's information by hand in the 21st century. I am not quite sure. Despite the "no wrong door" policy that allows Medicaid enrollment via the State or the marketplace websites, the online applications are apparently just being printed out and manually input into the system.

In Camden County, NJ, for example, there is a reported backlog of 10,000 Medicaid applications and only about 6 data entry personnel, meaning it would take nearly a year and a half to clear the backlog. So that is clearly an issue of concern as people are waiting for their enrollment verification so that they can see their doctor.

What steps will be taken to address the current backlog and to prevent more from happening in the future applications?

Secretary SEBELIUS. Well, Senator, we share your concerns. Frankly, it is not just States like New Jersey expanding Medicaid,

but it is States across the country that really have been on notice since the law was passed 4 years ago that they needed to update and upgrade their eligibility systems to make it seamless and easy for people to enroll. We are still finding a number of States like New Jersey that are not ready to receive automated data.

We are working closely with States around the country and frankly share your frustration that there are people waiting. There are also people probably in that line who may think they are Medicaid-eligible who are really marketplace-eligible and they do not even know that yet, so that is an additional problem.

But in terms of the automated system, the Federal system is ready to send automated reports and receive automated reports to try to seamlessly do this. We are actually kind of ramping up the pressure on States, and we will look at potentially some administrative reductions in payment if people do not pick up this pace, because having a backlog that is not being processed in a timely fashion is just keeping way too many people from the health care that they are entitled to.

Senator MENENDEZ. So in essence, States that have this backlog, it is because of their own lack of performance?

Secretary SEBELIUS. Well, at this point, yes. The Federal system did take a while to get to the point where we could actually process it electronically, but we are now at the point where we are able to input the electronic files. What we have is a system that goes back and forth between the States. So, somebody comes in at the State level and is marketplace-eligible; somebody comes in at the Federal level and is Medicaid-eligible. But most of what New Jersey is seeing is actually the New Jersey system not being able to keep up with the numbers of people who are qualified.

Senator MENENDEZ. Well, we would love for the Department to keep us apprised of how we are going to make progress.

Secretary SEBELIUS. We would be glad to.

Senator MENENDEZ. That is a lot of people.

Secretary SEBELIUS. Yes.

Senator MENENDEZ. Finally, last year CMS devised a new rule to determine whether or not a Medicare beneficiary would be considered an inpatient or an outpatient during their hospital stay solely based on whether their hospital stay spans more than 2 midnights. While it helps clarify some issues, we have all heard about beneficiaries spending a week or more in hospitals under observation status.

The rule fails to acknowledge an instance where a beneficiary needs a high level of inpatient care for a shorter amount of time, even if the physician determines it is medically necessary or appropriate. I think CMS has already acknowledged that there are problems with the rule and has delayed it on a number of occasions.

Additionally, Congress just stepped in and posed a statutory delay as part of the recent SGR bill, prohibiting enforcement until March 31, 2015. I have a bill with several members of this committee, who are co-sponsors, called the Two-Midnight Rule Coordination and Improvement Act.

But what is more important to me is that CMS has the existing authority to implement the provision of this bill, which basically is to have CMS consult with outside experts like hospitals and physi-

cians to develop the criteria methodologies that ensure beneficiaries in need of short-stay inpatient care are able to receive it and to make sure we do not have those long stays when they are not necessary. So can you give us some sense of whether we can make progress here without necessarily dealing legislatively with it?

Secretary SEBELIUS. Well, I think, given the fact that Congress, as you say, has chosen to delay the implementation, we will certainly be looking for strategies. I know there was a lot of consultation earlier, but I would love our staff to circle back with you and your staff to see what the elements are in the bill that we could perhaps move forward on an administrative basis.

Senator MENENDEZ. Thank you. Senator Fischer—it is a bipartisan bill, so I hope we can do that.

Secretary SEBELIUS. Great.

The CHAIRMAN. Thank you, Senator Menendez.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman. Madam Secretary, thank you for all your hard work. Washington State has, I think, the 6th-highest rate of marketplace enrollment in the country, so we obviously have had a lot of success in getting people coverage.

I wanted to talk about the fact that we have seen—my colleagues may have brought this up earlier, I am not sure—a lot of discussion in the *Wall Street Journal* and the *New York Times* about small segments of the physician community getting a lion's share of Medicare payment and reimbursement, or I think as one said, a tiny fraction of doctors getting like 25 percent or something.

So as you know, I have been very interested in the value-based modifier and implementation of that from the Affordable Care Act so that we can focus on healthy outcomes instead of the number of procedures performed. So I want to get an update from you on where we are in getting that implemented, and to also know if some of this other information, which is part of the mix of reimbursement that we do not have data on—things like the diagnosis, whether the care was necessary, the procedures performed, particularly on fewer than 10 patients, or data on durable medical equipment—whether we can make that information more transparent as well to help us in this effort of really focusing on outcomes instead of procedures.

Secretary SEBELIUS. Well, Senator, I know your interest in this area, and I certainly share it. I would say that the data released earlier this week was a big breakthrough. That data has been under Federal injunction since 1979, when an attempt was made to put it out that was blocked, and that injunction has been updated ever since. We at the Department joined with the *Wall Street Journal* and others asking the judge to lift the injunction, and I am pleased to say that the data is now available.

There is also—and we discussed this a little bit with Senator Grassley earlier—a portion of the Affordable Care Act which deals with the sunshine law and has some other data elements which will be collected, and we are on track to have, this fall, additional data sets available, because they are helpful to consumers to make good choices. It is also helpful to look at what providers are actu-

ally collecting. So we would love to work with you going forward on other data sets.

I think the determination, at least initially, about the 10 or more procedures was that sometimes collecting one at a time is a pretty scatter-shot look at the scenario and does not give you very comprehensive data. We want consumers to know, if you are going to go under the knife, if you will, for surgery, I think you would want to know who does the most hip replacements or knee replacements or whatever, who is the most familiar with that. So on one hand it is great consumer empowerment, and on the other hand it is also billing information that we think should be transparent with public dollars.

Senator CANTWELL. And then the value-based modifier?

Secretary SEBELIUS. Again, that is part of the, I think, initiatives going forward. It is certainly one of the looks that the Medicare team is making in how you can allocate adjustments to payments based on value and setting up a series of criteria of what exactly the outcomes are.

We are testing a lot of different models, including through Accountable Care Organizations. I would say that is probably the most promising set of tests, where not only cost is being watched closely, but certainly the quality outcomes for patients.

We have some very promising early results, and I see that as something that could be taken to scale in terms of what works very well. But the Innovation Center is probably testing 15 different models right now, which all would lend scientific data to the value-based modifier and give us ways that we could really change payments based on what works, to both increase quality and lower costs.

Senator CANTWELL. Well, I appreciate that. I just, for the record, am for more information being released. We kind of feel like we have already been the experiment, and we have provided better care at lower cost and consequently get lower reimbursement rates. I would not say we are all fine with that, but we certainly would be more amenable to that continuing if the rest of the country would follow suit.

Secretary SEBELIUS. And you do not want to be punished for it.

Senator CANTWELL. Exactly.

Secretary SEBELIUS. Yes.

Senator CANTWELL. We would rather be rewarded.

Secretary SEBELIUS. Yes. Got you.

Senator CANTWELL. So I think transparency will help us on outcome, yes. So thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Well said, Senator Cantwell.

Senator Bennet?

Senator BENNET. Dead last.

The CHAIRMAN. The best.

Senator BENNET. No, I would not say that, but thanks for calling on me, Mr. Chairman. I appreciate it.

Madam Secretary, it is good to see you again. I am glad we are here under these circumstances and not circumstances some had predicted in October. I am glad there are more than a quarter of

a million Coloradans who now have health insurance who did not have it before this law was passed.

But like you, I have worked at different levels of government, and I do think that what we saw in the fall is a reminder that we may not be up to the task in the 21st century when it comes to certain things like IT, and procurement, and customer service.

My hope is that, as the politics around this bill subside, which I deeply hope they will, because at home, health care is the farthest thing from a political issue for people. It is a day-to-day how-people-live-their lives issue, but as it subsides, I think that any wisdom that has been acquired through those brutal days in the lead-up to it that could benefit other agencies or other levels of government, even as Senator Menendez was talking about just a minute ago, I think you could provide a huge service at some point by—I do not know whether it is leading a discussion or having an interagency initiative in the Federal Government. This is the work that no one ever gets to. You know that.

Secretary SEBELIUS. Right. Right.

Senator BENNET. At the State level, the local level, the Federal level, no one ever gets to it. What it means in the 21st century, with the velocity of the world we are living in, is that we run the risk of finding ourselves in that position again someday. You do not need to react to that day, or you can if you want to, but that is just a thought. I think it would be a shame just to let that experience, as searing as it was, just disappear and for us not to learn what we need to learn from it.

The other topic I just wanted to raise at the end here is that, when we passed the law, CBO had some projections about what premiums would look like. I think that the actual premiums came in somewhere under 15 percent less than what CBO projected. If you look at the last 3 years, it has been the slowest rate of health care inflation in the last 50 years, which is saying something. The Medicare growth rate, I think we just learned, is minus 3.4 percent.

I wonder if you could just take a few minutes at the end here to help us understand what is going on out there. I mean, for years and years and years we have talked about trying to do things in Congress that might actually bend the cost curve in health care. Are we seeing the beginning of that? I mean, after all this *sturm und drang* and name-calling and all the rest, have we actually done something here, or is it too early to tell?

Secretary SEBELIUS. Well, I think there is no question, Senator, you have done something. I think in the early days of the Affordable Care Act, a lot of the cost reductions were attributed to recession and saying it really had to do with the economy and people not using health care as much, although I would argue that Medicare is a little recession-proof because you have a guaranteed package of benefits, and it really did not vary a lot with the recession.

But having said that, now that we have crossed year 4 and we are seeing really a fundamental shift, I think some of it is due to the framework that was put in place as part of the Affordable Care Act, not only in directions to reduce costs and increase quality in Medicare and in Medicare Advantage, but also delivery system re-

form, the very strong signal that we needed to look at ways to lower overall costs.

So what I find to be intriguing and very encouraging is that it is not just Medicare spending which is down, it is overall health expenditures. So, in the 8 years 2001 to 2009, health expenditures per capita rose at just about 6 percent a year, and GDP per capita during that time was rising at 2.9 percent a year. So, health care was dramatically over it.

In 2012, GDP per capita rose at about 3.8 percent, and health expenditures—and this is everything, not just the public programs—were at 3 percent. So we have come from twice as high to underneath. Medicare is significantly underneath. Those trends, as you say, were just updated, going down even further. Medicaid is on a trend line going down, and private health insurance is on a trend line going down.

So I think the news is good. What we are trying to do is capture exactly where those expenditures are. Some of it is hospital days, some of it is some of the work being done around hospital-acquired infections, some has to do with, I think, efforts on the preventive side. But what you have done in the Affordable Care Act, at least on the public program side, is to give us an indication that, if you find things that work, you can take them to scale without running a demonstration project and then coming back and doing them. So there is an opportunity really to accelerate this as we learn more.

Senator BENNET. Well, and I know my time is up, but, Mr. Chairman, as we think about this on a going-forward basis, these trends all look good. Obviously the real question is whether they are sustainable over time.

Secretary SEBELIUS. Right.

Senator BENNET. And we ought to be watching for that. But I do think the committee, I hope, would be interested in getting that data from you in real time so we can understand what is working well and what is not working well so we can help people at home who are trying to deliver care at a lower cost, bring that to scale, and not just wait for the next—who knows when it is going to come—discussion we are going to have about health care.

We have a bill in place. We are collecting data. We ought to be transmitting that data, and we ought to be surging ahead with the stuff that is actually out there that is working. A lot of it is in my State, and I know the other States around here as well.

Secretary SEBELIUS. Well, Chairman Wyden and I have had some conversations about the possibility of briefing this committee and others about the Innovation Center, which was created as part of this—what is being tested and tried, what we know about, what those results are. Some of it is at the State level, some of it is with dual-eligibles, some of it is directed to the delivery system, but it is very promising information, and we would love to do that.

Senator BENNET. And ultimately have that in the form of reimbursement.

Secretary SEBELIUS. Yes. Which is exactly——

Senator BENNET. That is what we need to do.

Thank you, Mr. Chairman.

The CHAIRMAN. That is a very good point to quit on. I am just going to leave you with one thought as we get you out the door,

Secretary Sebelius. I have been struck over the last couple of hours at how often the conversation focused essentially on the nuts and bolts of improving health care policy.

If you look at the issues that came up on matters like Medicare Advantage, the critical access hospitals, value purchasing, and children's health care, these are all areas where Democrats and Republicans can work together and with the administration in a constructive kind of way.

This was not about turning back the clock to the days when you could discriminate against people with preexisting conditions; this was about the opportunity for Democrats and Republicans to work together to improve health care. We are going to have a lot more conversations like that in the days ahead. We thank you for your patience, and we will excuse you at this time.

Secretary SEBELIUS. Thank you.

The CHAIRMAN. The Finance Committee is adjourned.

[Whereupon, at 12:18 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER U.S. SENATE COMMITTEE ON FINANCE HEARING OF APRIL 10, 2014 ON THE PRESIDENT'S BUDGET FOR FISCAL YEAR 2015 FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, today delivered the following remarks at a committee hearing examining the President's budget proposal for Fiscal Year (FY) 2015 with Health and Human Services Secretary Kathleen Sebelius:

Mr. Chairman, thank you for scheduling today's hearing. Secretary Sebelius, thank you for taking the time to be here today.

This discussion is long overdue.

Mr. Chairman, the President's budget was released on March 4th – 37 days ago.

Typically, these hearings are scheduled within days after the release of the budget. Indeed, it is generally considered to be routine to have budget hearings immediately. Yet, here we are – more than a month later – finally sitting down to discuss the HHS provisions of the President's budget.

That type of lag time is disappointing to say the least.

That said, the delay in holding this hearing is not the only delay that I'm concerned about today.

Madame Secretary, each time you have appeared before this committee, I have asked you to be prompt when responding to our communications, especially those dealing with the implementation of the Affordable Care Act. Yet, numerous inquiries submitted to HHS by members of Congress have been ignored entirely. And, we have yet to receive answers to the questions submitted for the record after your last appearance before this committee on November 6th of last year.

This committee takes its oversight responsibilities very seriously, Madame Secretary. I hope that, in the future, you will be more cooperative and responsive to these efforts.

Mr. Chairman, given how HHS has responded to our past attempts to exercise oversight, I think we may have to schedule another hearing with the Secretary in the near future. That might be the only way that our members will get answers to the questions they submit after this hearing.

Secretary Sebelius, process matters aside, I have some specific policy concerns that I hope you'll be able to address today.

For example, according to the President's proposed budget, combined spending for Medicare and Medicaid is expected to exceed $11 trillion over the next decade.

That's simply an astronomical number. And, we're only talking about two separate federal programs.

Entitlement spending has become a generational challenge that demands all of our attention. However, the administration appears all too willing to continue to ignore these problems.

The proposed budget would save a meager $414 billion over the next decade, or roughly 3.7 percent of total Medicare and Medicaid spending. And, it would do so primarily through provider cuts and government price controls.

Anyone who has spent more than five minutes looking at our budget has concluded that these programs are in serious trouble and that they are, along with Social Security, the main drivers of our debts and deficits. The non-partisan Congressional Budget Office, for example, has referred to our health care entitlements as our "fundamental fiscal challenge."

I hope that, during today's hearing, we can get some answers about entitlement reform because it is, quite frankly, one of the elephants in the room when we're talking about our nation's fiscal future.

Another elephant in the room is the implementation of Obamacare.

Last week, President Obama took to the Rose Garden to spike the football and declare his health law a "success" after it was announced that 7.1 million people had enrolled in the program.

So far, the administration has spent at least $736 million on advertising for Obamacare. The healthcare.gov website has cost more than $317 million. The call centers have cost at least another $300 million.

So, using the most conservative estimates, the total costs of the website and the advertising have, to date, amounted to just over $1.3 billion.

That's a lot of taxpayer money, especially when you look at all the outstanding questions like:

How many of those people will actually pay premiums?

How many of them already had health insurance BEFORE the law went into effect?

So far, it appears that the administration is hoping that the public will ignore these important questions and only focus on the number of claimed enrollees.

In fact, Secretary Sebelius, in your testimony before the House Energy and Commerce Committee, in response to some of these very questions, you stated that members of Congress would have to go ask the insurance companies because you and your department weren't keeping track of these figures.

Now, it is my understanding that the 7.1 million enrollees touted by the administration is merely a count of those who have selected an insurance plan through the exchanges, not of those who have actually purchased and paid for insurance.

That seems like an odd number to celebrate.

Indeed, it's like Amazon.com taking stock of how many people have placed items in their shopping carts and then counting them as sales.

In other words, it's a false metric. It is certainly not one that can justify the President's attempt to declare that the debate over his health care law is officially over.

There are many other questions that need answered with regard to Obamacare.

For example, so far, the administration has made more than 20 unilateral changes to the law. What is the cumulative cost of those changes?

While we're on the subject, how many more delays and changes are yet to come?

As you can see, there are a number of important matters to discuss today, both with regard to the President's budget and the implementation of Obamacare. I hope that we can have a serious discussion about these critical issues.

Madame Secretary, I know you have one of the most difficult jobs in Washington. I appreciate you being here.

Thank you, once again, Mr. Chairman for holding this hearing.

Thank you.

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STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

THE PRESIDENT'S FISCAL YEAR 2015 BUDGET

BEFORE THE

COMMITTEE ON FINANCE

UNITED STATES SENATE

APRIL 10, 2014

Testimony of
Secretary Kathleen Sebelius
U.S. Department of Health and Human Services
before the
U. S. Senate
Committee on Finance
April 10, 2014

Chairman Wyden, Ranking Member Hatch, and Members of the Committee, thank you for the invitation to discuss the President's FY 2015 Budget for the Department of Health and Human Services (HHS).

This budget for the Department of Health and Human Services (HHS) improves the economic opportunity of all Americans by providing critical investments in scientific research, health care, disease prevention, social services, and children's well-being, to achieve healthier families, stronger communities, and a thriving America. While it invests in areas that are critical to our long-term prosperity, the budget also helps tackle our deficit with legislative proposals that would save an estimated net $356 billion over 10 years. The Budget totals $1.0 trillion in outlays and proposes $77.1 billion in discretionary budget authority, a reduction of $1.3 billion from FY 2014 enacted. With this funding HHS will continue to improve health care and expand coverage, create opportunity and give kids the chance to succeed, protect vulnerable populations, promote science and innovation, protect the nation's public health and national security, and focus on responsible stewardship of taxpayer dollars.

Strengthening Health Care and Continuing Effective Implementation of the Affordable Care Act

Expanding Health Insurance Coverage. As of January 1, 2014, millions of Americans gained access to new health insurance options previously not available to them. The Marketplaces provide improved access to insurance coverage, creating a new private health insurance market in which those in need of coverage are more easily able to purchase health insurance. On March 31, 2014, the first open enrollment period ended. So far over 7 million Americans have signed up for private health insurance, and that number will grow as state-based Marketplaces report their numbers for the final day of open enrollment. New premium tax credits and rules ensuring fair premium rates are making private coverage more affordable for consumers. The Budget supports continued operations in the federally-facilitated Marketplace, as well as oversight and assistance to state-based and Partnership Marketplaces.

The Affordable Care Act provides full federal funding to cover newly eligible adults in states that expand Medicaid up to 133 percent of the federal poverty level for three years starting in 2014 and covers no less than 90 percent thereafter. The Affordable Care Act also simplified Medicaid and Children's Health Insurance Program (CHIP) eligibility and enrollment processes and aligned them with Marketplaces. Just last week we announced that 3 million additional individuals enrolled in Medicaid or CHIP through the end of February 2014. The Centers for Medicare & Medicaid Services (CMS) continues to work with states and other partners to advance state efforts that promote health, improve the quality of care, and lower health care costs.

Also beginning in 2014, consumers will benefit from a number of new protections in the private health insurance market. Non-grandfathered health plans will no longer be allowed to

charge more or deny coverage to people because of pre-existing conditions. These new protections will also prohibit non-grandfathered plans from putting annual dollar limits on benefits and from varying premiums based on gender or any factor other than age, tobacco use, family size, or geography. In addition, new plans in the individual and small group market will be required to cover a comprehensive package of items and services known as Essential Health Benefits, which must include items and services within ten benefit categories. Finally, many individuals will find it easier to participate in clinical trials because issuers will have to cover their routine patient costs and cannot deny their participation in trials. This protection applies to all clinical trials that treat cancer or other life threatening diseases.

Health Centers. Health centers will continue to be a vital source of primary care for uninsured and medically underserved patients seeking a quality source of care in FY 2015. The Budget requests $4.6 billion for health centers, $3.6 billion of which is funded by the Affordable Care Act's Community Health Center Fund, to serve approximately 31 million patients in FY 2015. These resources will support the establishment of 150 new health center sites as well as enhance quality, and support capital development and facility improvements at currently existing health centers.

Health Care Workforce. The Budget makes new and strategic investments in our nation's health care workforce to ensure rural communities and other underserved populations have access to doctors and other providers. In total, $14.6 billion will be invested in three key initiatives: $4.0 billion in expanded funding for the National Health Service Corps, $5.2 billion for a new Targeted Support for Graduate Medical Education program, and $5.4 billion for enhanced Medicaid reimbursements for primary care.

The $4.0 billion in new mandatory resources from FY 2015 through FY 2020 is in addition to $100 million in discretionary funding and $310 million in current law funding for FY 2015 for the National Health Service Corps. Corps clinicians serve in medical facilities in high-need areas of the country. This investment is projected to support 15,000 clinicians in FYs 2015-2020.HRSA will also invest in our nation's health workforce through the new Targeted Support for Graduate Medical Education program. Between FY 2015 and FY 2024, $5.2 billion in total mandatory funding is requested for this effort, to be distributed to teaching hospitals, children's hospitals, and to community-based consortia of teaching hospitals and/or other health care entities. The focus of the targeted support program will be to support ambulatory and preventive care, in order to advance the Administration's goals of higher value health care that reduces long-term costs. This investment will support 13,000 residents over ten years.

Concurrent with these efforts at HRSA, CMS will devote $5.4 billion to extend enhanced reimbursements to states for primary care through the end of calendar year 2015, expand eligibility for reimbursements to mid-level providers, including physician assistants and nurse practitioners, and exclude emergency room codes to better target primary care.

Protecting Vulnerable Populations

Elder Justice. The FY 2015 Budget proposes $25 million in the Administration for Community Living (ACL) to protect vulnerable older adults by combating the rising scourge of elder abuse, neglect, and exploitation in America. This effort builds on the findings and recommendations of the Elder Justice Coordinating Council, a consortium of federal partners which I lead that was established by the Elder Justice Act of 2009. In response to the recommendations of the Council, ACL will begin developing a national Adult Protective

Services data system and provide funding for key research. This investment will help states improve the quality and consistency of their Adult Protective Services programs.

Advancing Scientific Knowledge and Innovation

Protect Patients from Healthcare-Associated Infections. The CDC estimates that one in 20 hospitalized patients acquires a healthcare-associated infection (HAI), and over one million HAIs occur across the healthcare spectrum each year at a cost of over $30 billion. HHS is committed to reducing the national rate of HAIs. The Budget includes $44 million for HAI prevention activities at CDC, which include identifying emerging threats and protecting patients through outbreak detection and control, laboratory testing of the health care environment and contaminated products, and guideline development.

Complementing CDC's efforts, the Agency for Healthcare Research and Quality (AHRQ) focuses on conducting research to develop new methods of preventing and reducing HAIs, and disseminates these research findings to clinicians. The request includes $34 million for AHRQ's efforts to protect patients from HAIs.

Improving Healthcare through Meaningful Use of Health IT. Health information technology is essential to improving our nation's health care by moving from a transaction based system to one that emphasizes quality and value. The Budget includes $75 million for the Office of the National Coordinator for Health IT (ONC) to coordinate and support investments in policies, standards, testing tools, and implementation guides that have dramatically accelerated the adoption and meaningful use of certified Electronic Health Record technologies. Within this total, ONC will begin to address HIT-related patient safety issues under the Health IT Safety Center through data collection and analysis on the types and frequencies of health IT related adverse events. ONC will work closely with AHRQ, Patient Safety Organizations, the Joint Commission, and FDA on this effort.

Supporting Families

Maternal and Child Health. The FY 2015 Budget requests $1.3 billion to improve the health of mothers and children, an increase of $129 million. This level includes $500 million in FY 2015 and $15 billion through FY 2024 to extend and expand the Maternal, Infant, and Early Childhood Home Visiting program, through which states are implementing voluntary, evidence-based home visiting programs that enable nurses, social workers, and other professionals to meet with at-risk families and connect them to assistance to support the child's health, development, and ability to learn. These programs have been shown to improve maternal and child health and developmental outcomes, improve parenting skills and school readiness. The request also includes $634 million, the same as FY 2014, for the Maternal and Child Health Block Grant.

Early Head Start—Child Care Partnerships. The Budget proposes $650 million in FY 2015 for Early Head Start – Child Care Partnerships, an increase of $150 million above FY 2014. These funds will provide access to high-quality early learning programs for tens of thousands of infants and toddlers through competitive grants to new and existing Early Head Start programs that partner with child care providers, especially those receiving federal child care subsidies.

Child Support and Fatherhood Initiative. The Budget includes a set of proposals to encourage states to pay child support collections to families rather than retaining those payments. This effort includes a proposal to encourage states to provide all current monthly child support collections to Temporary Assistance for Needy Families (TANF) recipients. The proposal requires states to include provisions in initial child support orders addressing parenting time

responsibilities, to increase resources to support and facilitate non-custodial parents' access to and visitation with their children, and to implement domestic violence safeguards. The Budget also includes new enforcement mechanisms such as requiring states to implement electronic income withholding orders that will enhance child support collections. The Budget proposes an investment of $1.8 billion over ten years for these initiatives.

Facilitating Transitions to Adulthood

Demonstration to Address the Over Prescription of Psychotropic Medications for Children in Foster Care. The Budget includes $500 million for a new CMS demonstration in partnership with ACF to provide performance-based incentive payments to states through Medicaid, coupled with $250 million in mandatory child welfare funding to support state infrastructure and capacity-building. This transformational approach will encourage the use of evidence based screening, assessment, and treatment of trauma and mental health disorders among children and youth in foster care in order to reduce the over prescription of psychotropic medications. This new investment and continued collaboration will improve the social and emotional outcomes for some of America's most vulnerable children. I would like to thank Senator Grassley and other members of this Committee for expressing interest in the Administration's focus on this area, and I look forward to working with the Committee to address this need.

Continuing Program Integrity and Oversight

Combating Fraud, Waste, and Abuse in Health Care. The FY 2015 Budget makes cutting fraud, waste, and abuse a top Administration priority. In addition to the base discretionary Health Care Fraud and Abuse Control (HCFAC) funding in FY 2015, the Budget seeks new mandatory funding. Starting in FY 2016, the Budget proposes that all new HCFAC investments be mandatory, consistent with levels in the Budget Control Act. This investment supports fraud prevention initiatives like the Fraud Prevention System; reducing improper payments in Medicare, Medicaid, and CHIP; and HHS-Department of Justice Health Care Fraud Prevention and Enforcement Action Team initiatives, including the Fraud Prevention Partnership between the federal government, private insurers, and other key stakeholders. The Budget's 10 year investment in HCFAC yields a conservative estimate of $7.4 billion in Medicare and Medicaid savings.

To help ensure the prudent use of federal funds, the Budget also includes $25 million in discretionary HCFAC funding for program integrity activities in private insurance, including the Health Insurance Marketplaces.

The Budget includes $400 million in discretionary and mandatory funding for the Office of Inspector General (OIG), an increase of $105 million above FY 2014. This increase will enable OIG to expand CMS Program Integrity efforts for the Health Care Fraud Prevention and Enforcement Action Team and improper payments, and also enhance investigative efforts focused on civil fraud, oversight of grants and the operation of Affordable Care Act programs.

The Budget also includes $100 million for the Office of Medicare Hearings and Appeals (OMHA), an increase of $18 million above FY 2014. OMHA received over 600,000 claims in FY 2013 compared to 313,000 received in FY 2012. The Budget will support adjudicatory capacity and central operations case processing in order to address a critical backlog in the number of appeals and maintain the quality and accuracy of its decisions.

Medicaid Program Integrity. States have the primary responsibility for combating fraud and abuse in the Medicaid program. CMS supports this effort through technical assistance and by contracting with eligible entities to carry out reviews, audits, identification of overpayments, education activities, and technical support. Other key CMS efforts include measuring Medicaid improper payments and efforts to transform the Medicaid data enterprise through the Medicaid and CHIP Business Information and Solutions program to provide states, auditors, and reviewers timely access to more complete encounter data and other claims information. The Budget includes an additional $25 million per year, adjusted for inflation, for the Medicaid Integrity Program.

Responsible Stewardship of Taxpayer Dollars

Contributing to Deficit Reductions while Maintaining Promises to all Americans. The FY 2015 Medicare and Medicaid legislative proposals seek to strengthen these programs through payment innovations and other reforms that encourage high quality and efficient care while continuing to reduce health care cost growth. Medicare savings would total $407 billion over 10 years by encouraging beneficiaries to seek value in their health care choices, strengthening provider payment incentives to promote high-value, efficient care, and lowering drug costs. The Budget includes $7.3 billion in savings over 10 years to make Medicaid more flexible, efficient, and accountable. Together, the FY 2015 legislative proposals allow HHS to support the Administration's complementary goals of investing in the future and establishing a sustainable fiscal outlook.

Opportunity, Growth, and Security Initiative

The Budget proposes a $56 billion, government-wide initiative to support both domestic and security expenditures that reflect the President's priorities to grow the economy and create opportunities. Resources for the initiative would be offset with a balanced package of spending reductions and the closing of tax loopholes. Multiple, specific HHS programs would benefit from the initiative. One example is:

Head Start. The initiative would also provide an additional $800 million to further expand Early Head Start – Child Care Partnerships. This investment would bring total funding for Early Head Start – Child Care Partnerships to $1.5 billion in FY 2015, and provide access to high-quality early learning programs for a total of more than 100,000 children.

Thank you for the opportunity to testify. I will be happy to answer any questions you may have.

United States Senate Committee on Finance
Public Hearing
"The President's Budget for Fiscal Year 2015"
April 10, 2014

Questions Submitted for the Record

Senator Ron Wyden:

Questions for the Witness:

The Council of Economic Advisors reports that health care spending growth over the last three years is at its lowest rate since 1965. Slow spending growth is having a major impact on the federal budget. In February of 2013, the Congressional Budget Office adjusted its ten year spending projections to account for slowed growth and determined that Medicare spending will be $143 billion lower than they previously estimated over ten years. The Congressional Budget Office has said that Medicare spending is at a historic low and is projected to stay there. This is great news for seniors who want lower premiums. This is great news for future generations who want Medicare to be around when they need it. This is great news for our country as budget deficits continue to shrink.

1. **Is this slowdown reflected in the President's Budget, and do you expect the slowdown will continue?**

Answer: The recent slowdown in Medicare spending growth has been great news for beneficiaries and taxpayers alike. Keeping the rate of growth low in the coming years will require a lot more hard work. But doing so is essential in order to meet our collective commitments to seniors and address our long-term budget deficits. The reforms included in the Affordable Care Act constitute a sound, sustainable, and careful approach to slowing the growth of Medicare.

Over the last few years, health care spending growth has fallen to the lowest levels since the government started tracking these data in the 1960s. Data from the Centers for Medicare and Medicaid Services and the Bureau of Economic Analysis show that, from 2010 to 2012, health care spending grew at an annual rate of just 1.1 percent in real inflation-adjusted per capita terms, a small fraction of the 4.0 percent average annual rate over the first part of the last decade.

While some portion of the slow-down is attributable to the business cycle, evidence suggests that a substantial fraction is probably structural, meaning that it reflects factors more likely to persist once the economy fully recovers. One notable structural factor contributing to the slowdown is the Affordable Care Act (ACA), which is lowering costs and improving quality by reducing excessive Medicare payments to private insurers and providers, deploying new payment models that encourage more efficient, higher quality care, and creating strong incentives for hospitals to reduce readmission rates.

The slowdown in health spending is already yielding substantial fiscal dividends. Compared with the 2011 Mid-Session Review (MSR), aggregate projected federal health care spending between 2014 and 2020 has decreased by more than $1 trillion based on current budget estimates.

The Budget builds on the savings and reforms in the ACA with additional measures that will help ensure health care cost growth remains low and help improve quality of care.

There is evidence that these reforms are already working. Medicare spending per beneficiary grew at about 1.6 percent per capita from 2010 through 2013. However, over the next ten years, the CMS actuaries project a higher annual per capita growth rate in Medicare spending of 3.7 percent. This growth in per capita spending can be attributed to higher overall economic growth as well as the aging of the baby boomers who are now entering into Medicare. Nevertheless, average annual Medicare spending per capita is still projected to grow slower than GDP per capita over this time period. In addition, the proposals in the President's Budget, if enacted, will further restrain Medicare spending growth – lowering the average per capita growth rate to fewer than 3 percent and saving Medicare over $400 billion.

Some claimed that the Affordable Care Act would ruin Medicare Advantage as we know it. In fact, the opposite has occurred. Since the ACA was signed into law, Medicare Advantage premiums have fallen by nearly 10 percent. At the same time, enrollment has increased by 38 percent to an all-time high of over 15 million seniors. Nearly 30 percent of Medicare beneficiaries are in a Medicare Advantage plan. In parts of Oregon more than half of all Medicare beneficiaries are in Medicare Advantage plans. Not only is enrollment up and costs down, but quality has improved. Medicare Advantage enrollees now have more high quality 4-star plans to choose from.

2. Madame Secretary, how do you view the future of Medicare Advantage?

Answer: I expect Medicare Advantage (MA) will continue its strong performance into the future. With enrollment at an all-time high and costs remaining stable, concerns that recent changes to the MA program would result in lower enrollment and higher costs now appear unfounded. Nationwide, over 15 million Medicare beneficiaries are now enrolled in an MA plan. This is a 30 percent increase in enrollment since 2010, and enrollment is projected to continue increasing. Plan participation continues to be robust with 99.1 percent of beneficiaries having access to an MA plan in their area. The average MA premium in 2014 is projected to increase by only $1.64 from last year, coming to $32.60. At the same time, the average number of plan choices will remain about the same in 2014, and access to supplemental benefits remains stable. Additionally, since passage of the Affordable Care Act, average MA premiums are down by 9.8 percent. Robust access, improving quality, growing enrollment, slow-growing premiums, and stable plan choices are all indications that the MA program can be expected to remain strong in the coming years.

The ACA is transforming the health insurance market for Americans who are not offered coverage by their employer. Because of the ACA, insurers are no longer able to deny

coverage or charge different premiums based on an individual's gender, medical history or current health status. Insurers are also prohibited from imposing annual or lifetime limits on a consumer's insurance benefits, and have to offer a standard set of minimum essential health benefits to all of their customers.

3. **Can you go into some detail on how the ACA will benefit Americans who purchase their own health insurance through the marketplace? What type of coverage are these folks getting?**

Answer: Consumers who purchase coverage through the Marketplace can be confident that their insurance will cover them when they need it. All private health insurance plans offered in the Marketplace will offer coverage of benefits in the same categories of essential health benefits. These are types of services all plans must cover. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

It is also important to remember that these essential health benefits are minimum requirements for all plans in the Marketplace. Plans may offer additional coverage. Consumers are able to see what each plan offers when they compare them side-by-side in the Marketplace.

Improving the quality and safety of care provided to Medicare beneficiaries and bending the cost curve will require substantial changes to the way that health providers deliver care. The administration is advancing a number of projects to initiate change by incentivizing better coordination of care between providers, better management of chronic disease, and better incentives to deliver high-value care instead of a high volume of care. These projects include value-based payment programs for hospitals that incentivize lower readmissions and hospital-acquired conditions, accountable care organizations, demonstrations on bundled payments for hospitals and post-acute care facilities, and demonstrations on patient-centered medical homes.

4. **How is the administration promoting delivery system reforms that will improve the quality and safety of care provided to beneficiaries and continue to bend the cost curve?**

Answer: The Affordable Care Act includes tools to improve the quality of health care that can also lower costs for taxpayers and patients. This means avoiding costly mistakes and readmissions, keeping patients healthy, rewarding quality instead of quantity, and building on the health information technology infrastructure that enables new payment and delivery models to work. These reforms and investments will build a health care system that will ensure quality care for generations to come.

CMS continues to make changes to the Medicare Physician Fee Schedule and other Medicare payment policies to improve efficiency and accuracy in Medicare payment and the quality of care for our beneficiaries. We have improved payment for primary care services, while enhancing our efforts to address payment for misvalued services under the physician payment system.

We have also begun to implement important delivery system reforms included in the Affordable Care Act. Accountable Care Organizations (ACOs) are an example of an initiative showing signs of success in delivering high value care. On January 30, 2014 CMS released the interim financial results for the Medicare Shared Savings Program ACOs, which showed that in their first 12 months, nearly half (54 out of 114) of the ACOs that started program operations in 2012 already had lower expenditures than projected. An independent preliminary evaluation of the Pioneer ACO Model - the ACO model designed for more experienced organizations prepared to take on greater financial risk - shows that of the 23 Pioneer ACOs, nine had significantly lower spending growth relative to Medicare fee for service. These findings demonstrate that ACOs of various sizes and structures across the country are working to better coordinate care while reducing expenditure growth.

Through the Hospital Value-Based Purchasing Program, CMS is changing the way it pays hospitals, rewarding hospitals for the quality of care they provide to Medicare patients, not just the quantity of procedures they perform. Hospitals are rewarded based on how closely they follow best clinical practices and how well hospitals enhance patients' experiences of care. When hospitals follow proven best practices, patients receive higher quality care and see better outcomes.

5. Which programs are showing success at delivering high-quality, high-value care?

Answer: Accountable Care Organizations (ACO) are an example of a model showing signs of success. On January 30, 2014 CMS released the interim financial results for the Medicare Shared Savings Program ACOs, which showed that in their first 12 months, nearly half (54 out of 114) of the ACOs that started program operations in 2012 already had lower expenditures than projected. Of the 54 ACOs that had savings in relation to their benchmarks in the first 12 months, 29 generated shared savings totaling more than $126 million – a strong start this early in the program. In addition, these ACOs generated a total of $128 million in net savings for the Medicare Trust Funds. ACOs share with Medicare any savings generated from lowering the growth in health care costs while meeting standards for high quality care. Final performance year-one results will be released later this year.

An independent preliminary evaluation of the Pioneer ACO Model - the ACO model designed for more experienced organizations prepared to take on greater financial risk shows Pioneer ACOs generated gross savings of $147 million in their first year while continuing to deliver high quality care. Results showed that of the 23 Pioneer ACOs, nine had significantly lower spending growth relative to Medicare fee for service while exceeding quality reporting requirements. These findings demonstrate that organizations of various sizes and structures across the country are working with their physicians and engaging with patients to better coordinate and deliver

high quality care while reducing expenditure growth. We look forward to sharing updated results later this year.

6. **In January, CMS released the results of the first year of the Pioneer ACO and Medicare Shared Savings Program ACO initiatives demonstrating savings by a large number of participating organizations. What are the primary differences between ACOs that were able to generate shared savings by meeting cost targets and those that were not able to meet cost targets?**

Answer: ACOs that earned shared savings were diverse in terms of size, organizational composition, geographic location, baseline Medicare spending, baseline Medicare spending growth, and the types of populations that they served. We do not have sufficient data at this stage to definitively identify characteristics that distinguish them from ACOs that did not earn shared savings. While it is still early, we note that the spending reductions generated by Pioneer ACOs appear to be driven by reductions in use of physician and outpatient services.

7. **The administration recently released data on the success of the incentive program to reduce hospital readmissions. What are the factors that are driving down the number of patients who are readmitted to hospital within 30 days of their initial discharge? What impact is this having on beneficiaries who are discharged from the hospital?**

Answer: We believe that the alignment of work across multiple federal and private sector initiatives is contributing to the significant national reductions in readmissions. The Medicare Readmissions Reduction Program, the Community-Based Care Transitions Program, Quality Improvement Organizations, Partnership for Patients Hospital Engagement Networks, and many private partners are all working together to contribute to the national improvement. Patients benefit from fewer unnecessary readmissions. This work has now led to over 130,000 beneficiaries between January 2012 and August 2013 staying home and healthy instead of being readmitted to the hospital.

Last week, CMS publicly released a data set containing the number and types of medical services provided by physicians and other health care professionals. This data contains information on more than 880,000 health care professionals in all 50 states who received a total of $77 billion in payments in 2012 for services delivered under Medicare Part B. This data set contains payment data on provider services, procedure codes, and locations where services were performed (e.g., doctor's office versus hospital). CMS has effectively begun to implement the main goals of the "Medicare Data Access for Transparency and Accountability Act" that you first introduced with Senator Grassley in 2011.

I am encouraged by the strides CMS has taken over the past year to give consumers increased access to Medicare data. Senator Grassley and I have been talking about the need for this level of transparency for a long time. CMS' release of Medicare provider data yesterday marks its most important step toward transparency.

8. What have you learned from this release already and how do you think beneficiaries and consumers will benefit?

Answer: With this data, it is possible to conduct a wide range of analyses that compare 6,000 different types of services and procedures furnished, as well as payments received by individual health providers. The information allows comparisons by physician, specialty, location, the types of medical service and procedures furnished, Medicare payment, and submitted charges. Early analyses have yielded new insights about the provider specialties with the highest Medicare payments, the specialties with the highest Medicare-allowed amount per individual physician, and how patterns of service use vary across physicians and specialties. More information on the analyses of the dataset is available at http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-04-09.html.

9. How will CMS build on this work to make this data more user-friendly while continuing to improve access to Medicare utilization and quality data? Why not make this information easier for consumer to use by putting it on the Physician Compare page of the CMS website?

Answer: In April, CMS released a new interactive search tool that can help consumers and other stakeholders navigate information about the types of medical services and procedures furnished by physicians and other health care professionals. This new look-up tool makes it easier to use the large data set about physician information that CMS released on April 9, 2014 to look up specific providers. Users can search for a provider by name, address, or National Provider Identifier. Once a user selects a provider, the tool returns information about the services the provider furnished to Medicare beneficiaries, including the number of services furnished, the number of beneficiaries treated, and the average payment and charges for such services.

Led by the CMS Innovation Center, the State Innovation Models (SIM) Initiative provides funding and technical assistance to help states plan, design, and test new service delivery and payment models to advance broad health system reform focusing on people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Since launching the initiative in July 2012, CMS has awarded nearly $300 million to 25 states to design and launch State Health Care Innovation plans. Grantees included six "model-testing" states, which are moving ahead with their plans; three "model-pretesting" states, which are continuing to design their plans; and sixteen "model-design" states, which are creating their plans. On May 15, 2013, CMS announced round two of its health care innovation awards. In the initial announcement, CMS stated that it expected to announce the first phase of awardees of cooperative agreements on or about January 15, 2014, and the second phase of awardees of cooperative agreements on or about January 31, 2014. However, no such announcements have been made to date.

10. Can you provide an update on the status of round two of the Health Care Innovation Awards, including information on when CMS anticipates announcing the round two awardees?

Answer: The Health Care Innovation Awards Round Two Funding Opportunity Announcement requires that external expert panels assess and score qualified applications. That process has recently been completed and CMS is completing the application review process. Final award announcements are anticipated to be made in Spring/Summer 2014.

The Administration for Children and Families (ACF) and the GAO estimate that 18-39 percent of the 400,000 children in foster care in the United States are prescribed psychotropic medications. This is more than EIGHT TIMES the rate of children on Medicaid that are not in foster care. While children in foster care represent less than 3% of all enrollees in the Medicaid program, they account for 25–41% of all child-based mental health expenditures within the Medicaid program. The single largest group of children receiving these medications are those with disruptive/behavioral and attention deficit/hyperactive disorders. The general perception is that these medications are used in place of more time and cost intensive grief/trauma counseling sessions. Members of both parties (including Senators Hatch, Grassley, and Carper) have raised concerns over the treatment of mental health needs for youth in foster care. In 2011, Congress passed the Child and Family Services Improvement and Innovation Act requiring states to improve oversight of psychotropic medication for youth in care. HHS has also held conferences and issued guidance to states in an attempt improve service delivery and decrease the reliance on prescription drugs for youth in foster care.

Unfortunately, due to a lack of oversight and availability of mental health services in some state Medicaid programs, evidences suggests that states and providers are still overly reliant on mind-altering meds in addressing the mental health needs of children in foster care.

The President's budget proposes a five-year initiative between CMS and the Administration for Children and Families to provide performance-based incentive payments to states through Medicaid in order to reduce reliance on psychotropic medications for children in foster care by encouraging the use of evidence-based screening, assessment, and treatment of trauma and mental health disorders. ACF would receive separate funding to provide competitive grants for related purposes. This proposal is estimated to cost $665 million over 10 years.

The use of psychotropic drugs for the 400,000 children in foster care in the United States has reached epidemic proportions. Data suggests that foster children are receiving such drugs at a rate eight times that of Medicaid eligible children. Little is known about the long term effects of these medications on children's minds and bodies. Pilot projects have shown that psychiatric counseling can dramatically decrease psychotropic medication use and lead to decreased psychiatric hospitalizations, improved chances for permanent placement and decreased transfers to other foster homes. This Committee has supported

efforts to improve tracking and oversight of the use of prescription drugs for youth in foster care. I am appreciative of the efforts of HHS to address this issue and look forward to working with you in this area.

11. My question relates to ongoing efforts within HHS and particularly coordination between SAMHSA, ACF, and CMS. Aside from the budget proposal, what ongoing oversight efforts is HHS undertaking—or planning to undertake—to address the over-prescription of psychotropic mediations for youth in foster care and lack of more comprehensive mental health services?

Answer: HHS' Administration for Children and Families (ACF) monitors state compliance with federal child welfare requirements under titles IV-B and IV-E and the safety, permanency and well-being outcomes for children and families through the Child and Family Services Reviews (reviews). ACF has completed two reviews in every state since 2001 and is beginning a third round of reviews to occur during fiscal years (FYs) 2015 through 2018. As part of these reviews, ACF assesses the agency's efforts to support positive outcomes for children by using an onsite review instrument to review a sample of cases of children served by the state child welfare agency. ACF has always included an item in this instrument to consider a state's performance in assessing a child's mental and/or behavioral health needs and facilitating the receipt of appropriate services. We have revised the review instrument for the upcoming reviews to include a specific item on whether the agency provided appropriate oversight of prescription medicines for a child's mental health issues, including following the state's protocols for the appropriate use and monitoring of psychotropic medications. We believe this assessment will help provide information to states and help shape any further ACF guidance on addressing children in foster care's mental health needs appropriately.

Additionally, in FYs 2011, 2012, and 2013, ACF funded three successive cohorts of five-year discretionary grants focused on increasing children's psycho-social functioning, increasing permanency, improving adoption outcomes, and reducing unnecessary medication use by: 1) implementing universal mental health, behavioral health and trauma screening; 2) increasing access to trauma-informed and trauma-focused evidence-base interventions; and 3) introducing measurement-driven case planning, progress monitoring and service array reconfiguration.

ACF continues to actively partner with CMS and SAMHSA to reduce over-prescription of psychotropic medications for children in foster care by building State's capacity to prevent and mitigate the effects of trauma by supporting the development of: 1) service delivery capacity; 2) workforce and infrastructure; and 3) sustainable funding strategies.

Also, an ACF-led inter-agency work group is in the process of completing a guide for caseworkers, supervisors and caregivers on psychotropic medication (a companion to ***"Making Healthy Choices: A Guide on Psychotropic Medications for Youth in Foster Care"*** released in 2012 (available at http://www.nrcyd.ou.edu/learning-center/med-guide).

In addition, SAMHSA is continuing efforts to address the use of psychotropic medications with children and youth who experience behavioral health problems. SAMHSA partnered with the Center for Health Care Strategies (CHCS) to provide educational webinars based of the Faces of

Medicaid Data Analysis. SAMHSA is also extending educational opportunities by creating a Clinical Learning Community that will focus technical assistance efforts on developing alternatives to the use of psychotropic medications within grant communities and state children's behavioral health agencies.

Additionally, as part of the national evaluation of SAMHSA's Children's Mental Health Initiative (CMHI), SAMHSA is tracking the use of psychotropic medication and how services being delivered through a "system of care" framework are helping to reduce or avoid the use of psychotropic medications. Services delivered through a system of care approach can be used as an alternative to traditional services, including psychotropic medications, and this evaluation methodology will help SAMHSA develop and provide information about best practices in this area.

Despite a rocky roll-out, the Affordable Care Act is successfully achieving many of its primary objectives. Though much attention has been focused on the number of individuals who have enrolled through the Exchanges, other important aspects of the law are getting lost in the noise of political attacks.

12. Secretary Sebelius, what are the consequences of going back to a world where the Affordable Care Act consumer protections don't exist?

Answer: If the Affordable Care Act's consumer protections did not exist, consumers with pre-existing conditions could be denied insurance coverage on the basis of their health status. Health insurance companies could charge higher premiums to certain enrollees because of current or past health problems. Women could be charged more than men for health insurance, simply because of their gender. Older Americans could be charged five times or more than what younger Americans pay for health insurance coverage. Young adults under age 26 would no longer be guaranteed to be able to stay on their parents' health insurance plans. And people with cancer or other chronic illnesses could run out of insurance coverage when their health care expenses reached an annual or lifetime dollar limit imposed by their insurance policy or group health plan. The consumer protections in the Affordable Care Act address these and many other inequities of the health insurance market of the past. Thanks to the Affordable Care Act, millions of people have obtained coverage, and millions more now have the peace of mind that the coverage they have cannot easily be taken away.

Madame Secretary, as you know, I have been a champion for choice and transparency in our health care system. As Exchange implementation has evolved, there has been concern raised about the transparency of the pediatric dental benefit embedded in some Qualified Health Plans. Specifically, a recent study indicated that in 80% of medical plans with embedded pediatric dental benefits it was unclear whether the plan had a separate dental deductible. The study also indicated that in 92% of medical plans it was unclear whether orthodontia services were covered.

13. What can be done to make the purchase by parents of pediatric dental benefits for their children in embedded dental plans more transparent so these children can receive critical preventive oral health services?

Answer: CMS is committed to ensuring that HealthCare.gov provides the key information consumers need to make an informed selection from among the QHPs available to them. The Affordable Care Act requires that each plan in the Marketplace include a Summary of Benefits and Coverage (SBC) and a link to the plan brochure, where consumers can learn more about which services are covered and related cost-sharing information. Consumers may always contact plans prior to and after signing up for detailed information not contained in the SBC. Details on coverage of orthodontia services can also be obtained by examining the benefits covered in the plan brochure.

As a reminder, plans subject to the essential health benefits requirements providing pediatric dental benefits must provide benefits that are substantially equal to the benefits contained in the benchmark plan in that state. For pediatric dental services, if the benchmark plan did not include pediatric dental services, the plan was supplemented with the benefits of a State's CHIP plan or the FEDVIP dental plan.

Senator Orrin Hatch:

Questions for the Witness:

Under current law, the U.S. taxpayer subsidizes graduate medical education through a variety of programs—most notably Medicare, but also CHGME, and the Teaching Health Centers program. In addition, some state Medicaid programs subsidize training.

You have proposed a "Targeted Support for Graduate Medical Education program," for which $5.2 billion in mandatory funding over 10 years is requested, to be distributed through a new competitive grant program to teaching hospitals, children's hospitals, and community-based consortia of teaching hospitals or other health-care entities. According to the HHS Budget in Brief: "The focus of the targeted support program will be to support ambulatory and preventive care, in order to advance the Administration's goals of higher-value health care that reduces long-term costs." (BiB at p. 3). The Budget also makes clear that these funds are "aimed at supporting medical residency programs across the country that advance key workforce goals, including the training of more physicians in primary care and understaffed specialties and encouraging physicians to practice in rural and other underserved areas." (BiB at p. 23). Under your proposal, the new Targeted GME program would take the place of the current Teaching Health Center and CHGME programs.

14. Federal programs currently make GME payments to teaching hospitals and health centers based on eligibility, not based on a competitive process. Under the contemplated competitive process, what standards will guide your determination of which entity receives an award?

Answer: The competitive process for the Targeted Support for GME Program, including the criteria and standards for making awards to applicants, is currently in the preliminary stages of development. The new program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, including in rural and underserved areas. Programs will need to demonstrate that they provide diverse training experiences that will help ensure that we are training future physicians in the settings where we know patients get the bulk of their care, as well as being trained in the models of health care delivery that are most effective.

15. Among competing residency programs, each with different goals, how would HRSA administer the grant program to achieve the Administration's stated goals of supporting ambulatory and preventive care, and increasing production of primary care physicians?

Answer: The Targeted Support for GME program will support the training of 13,000 physicians over the next ten years n community-based, ambulatory care settings. The core focus of this new residency program will be primarily training primary care physicians. However, there are other high need specialties that may also be supported.

16. Residency training lasts a minimum of 3 years, and attracting and enrolling residents requires funding stability. Even the best residency program cannot attract quality residents if funding is contingent upon future grant awards. Under the contemplated competitive process, how will HRSA address the timing and length of the grant making process to ensure that quality community-based programs are able to make commitments to candidates far enough in advance?

Answer: The Targeted Support for GME program includes 10 years of mandatory funding in order to provide the financial resources necessary to support multi-year residency training, as well as anticipate future commitments for qualified candidates. Using a competitive selection process will enable HRSA to invest federal resources in programs that have the greatest likelihood of success and achieve strong performance outcomes. Multi-year grants will allow organizations to develop and implement new programs. We also expect that this improved training model will be attractive to medical students.

Secretary Sebelius, I want to make sure that the delay Congress just passed on ICD-10 implementation is the last delay we face. I want to see the transition to ICD-10 go live on October 1, 2015.

17. Is there any reason for us to fear we won't be ready for successful implementation? Was CMS on track to implement on October 1, 2014?

Answer: ICD-10 is an important part of health care reform, and will advance several integrated programs that build toward a modernized health care system and work in concert to achieve better care, better health, and lower costs. Standards such as Version 5010, the ICD-10 code set itself, the Medicare & Medicaid Electronic Health Record Incentive Programs, and the Physician Quality Reporting System are all aimed at accomplishing these outcomes. Together, these programs move America's health care system towards better coordinated care through greater interoperability and ease of transmitting electronic data; better quality measurement and reporting of clinical outcomes data; and lower costs achieved through operational efficiencies and administrative simplification. On May 1, 2014, we announced that we expect to release an interim final rule in the near future that will include a new compliance date for ICD-10 of October 1, 2015. CMS was on track to have all of its systems ready for ICD-10 implementation on October 1, 2014.

While the performance of the website has improved somewhat, one thing that has not improved is the exchange's ability to transfer Medicaid applications to states for simple enrollment.

18. How long will it take before the exchange can manage the task of transferring Medicaid applicants' information seamlessly?

Answer: The Federally Facilitated Marketplace (FFM) is able to transfer Medicaid accounts to all states that are prepared to receive them and, to date, the FFM has successfully transmitted more than 1.7 million accounts. The Centers for Medicare and Medicaid Services (CMS) is working closely with the few states that are not currently able to receive Medicaid account transfers from the FFM and have offered states that are currently not able to receive these transfers the option to enroll individuals based on information provided in account transfer flat files transmitted by CMS to states served by the FFM. Additionally, CMS contacted all individuals determined or assessed as Medicaid eligible in states that are not currently able to receive account transfers and encouraged them to apply directly with their state Medicaid agency until such time as their state is able to receive the electronic account transfer.

Your FY15 budget requests a ramp up of funds for program integrity. You requested that HCFAC funding be made mandatory instead of discretionary, and that these funds be increased significantly. In FY13, the HCFAC program's law enforcement recoveries were about $4.3 billion dollars, a small fraction of recoveries for a program that makes about $44 billion dollars in improper payments yearly. Moreover, the HCFAC recoveries represent mainly recoveries from cases under development for years and not pro-active fraud prevention efforts.

Your budget also touts the success of the Fraud Prevention System which was supposed to be the centerpiece of the Administration's anti-fraud efforts and last year only identified a paltry $115 million in fraudulent payments in its first year, none of which could be validated or verified by the HHS Office of Inspector General. This Committee has yet to

see any real results from the FPS, and we are still waiting for the 2013 FPS annual report which is several months overdue.

19. When can Congress expect to receive the 2013 Fraud Prevention System report? And why should Congress provide you with increased program integrity funds when you have not been able to demonstrate that you are effectively using the funds that you have?

Answer: The requested increase in HCFAC funding reflects this Administration's commitment to fighting fraud and the belief that this investment will pay off in significant returns to the Medicare Trust Funds by preventing improper payments before they occur. Additionally, this funding is necessary to keep pace with the growth of federal health programs and increasingly complex fraud schemes. Further, our funding request has bipartisan support and is in line with amounts specified in the Budget Control Act of 2011. The most recent HCFAC Report (FY 2013) displays the highest return-on-investment (8.1 to 1) since the program's inception.

CMS actuaries estimate that the additional HCFAC investment in the Budget will yield $7.4 billion in savings over 10 years. Fully funding program integrity efforts will allow CMS to expand its work to prevent fraudulent and improper payments before they occur. The historical pay-and-chase approach only addresses the problem after payments are made. Additional HCFAC funding in FY 2015 will support prevention-focused activities within CMS and Health Care Fraud Prevention and Enforcement Action Team (HEAT) initiatives in partnership with DOJ and OIG.

Since June 2011, CMS has been using the Fraud Prevention System (FPS) to apply advanced analytics on all Medicare fee-for-service claims on a streaming, national basis. CMS designed the FPS to accommodate different analytic model types to address a variety of fraud schemes. The most important indicator of success is that the models in the FPS have led to administrative action – CMS has used its revocation authority to remove bad actors from the Medicare program, which is the surest way to protect Trust Fund dollars and beneficiaries, suspended potentially fraudulent payments from going out the door, and referred leads and cases to law enforcement.

Early results from the FPS show significant promise and CMS expects increased returns as the system matures over time. As reported in the FPS FY 2012 Report to Congress, in its first year of implementation, the FPS stopped, prevented or identified an estimated $115.4 million in improper payments. These savings are the outcome of activities such as revocations of provider billing privileges, the implementation of payment edits, the suspension of payments, and changes in behavior that result from CMS actions. The FPS achieved a positive return on investment, saving an estimated three dollars for every one dollar spent in the first year; CMS anticipates that the ability of FPS to identify bad actors and focus investigative resources on most egregious schemes will continue to expand. As required by statute, CMS is working closely with the Office of Inspector General (OIG) to have savings estimates from the FPS certified and plans to issue the 2013 FPS Report to Congress soon.

With regard to demonstrations being conducted by the CMS Innovation Center, please provide the process by which you intend to convey results from the programs to Congress. Do to the significant financial resources devoted to the CMS Innovation Center, it is imperative to have regular and consistent status reports from the Administration.

20. Will you outline a process to communicate the results to Congress on a regular basis?

Answer: We are committed to communicating results from testing Innovation Center models to Congress and to the general public. As required by Section 1115A of the Act, the Secretary must publicly report the results of the evaluation of each model. These evaluation reports may be published on the Innovation Center's website or communicated through other avenues. Additionally, the Innovation Center is required to issue a biennial Report to Congress describing the models tested, including the number of individual participating in the models, payments made, models chosen for expansion, and the results from any evaluations.

21. With regard to the expansion authority granted to CMS through the CMS Innovation Center, what are the plans for rolling out using the authority for expansion of testing of the model?

Answer: Section 1115A of the Act gives the Secretary authority, through rulemaking, to expand (including implementation on a nationwide basis) the duration and the scope of model being tested after its evaluation if the expanded model is expected to reduce spending without reducing the quality of care or improve the quality of care without increasing spending, and the Chief Actuary of the CMS certifies that such expansion would reduce (or would not result in any increase in) net program spending. The Secretary must also determine that such expansion would not deny or limit the coverage or provision of benefits. At this time, no Innovation Center models have reached the point where they are being considered for expansion pursuant to section 1115A(c).

CMS has dedicated up to $1 billion over three years to test care models to reduce hospital-acquired conditions and improve transitions in care. How much of the $1billlion has been spent to date? Please provide specific answers to who has received the funds and what the expenditure has achieved. CMS has said these efforts have the potential to save 60,000 lives and reduce millions of preventable injuries and complications in patient care over the next three years and save up to $50 billion over 10 years.

22. What is CMS' progress to date with regard to the stated target of $50 billion in savings?

Answer: The Partnership for Patients has committed $430 million to date. These funds were provided to 27 Hospital Engagement Networks (HENs), and 3 national support contractors (Patient and Family Engagement, Program Evaluation, and the National Content Developer).

The Community-based Care Transitions Program (CCTP) also supports the Partnership for Patients. The Affordable Care Act provided$500 million in funding for CCTP. The Consolidated and Further Continuing Appropriations Act, 2013 (P.L. 113-6) rescinded $200 million of CCTP's $500 million appropriation. The majority of the remaining $300 million of available funds have been obligated to the 101 participating sites and CCTP program contractors.

Initial emerging results are encouraging. For example, there has been a 48 percent reduction in early elective deliveries at more than 1,000 hospitals across the country. Improvements are being seen across nearly all hospital-acquired conditions targeted by the Partnership. The Partnership for Patients is achieving early promising results, demonstrating the potential to accomplish national patient safety goals through collaborative improvement. We are in the process of analyzing results to date as well as savings and will share this information when it becomes available.

23. How is CMS differentiating between this effort and the multitude of other policy efforts aimed at similar outcomes?

Answer: CMS believes that alignment and synergy across multiple programs (federal and private sector) is contributing to the initial success of the Partnership for Patients, as was intended for this initiative. The Partnership for Patients has a rigorous evaluation strategy that is working to assess and evaluate the relative contributions of various elements of the overall effort.

24. How is CMS ensuring that these funds are being well spent and not duplicating efforts?

Answer: All contracts receive intensive oversight by a team of formally trained and certified CMS Contract Officers and Contracting Officer representatives, with managerial direction by experienced executives. The Hospital Engagement Networks (HENs) are under a contractual obligation to ensure that there are appropriate and well-documented coordination mechanisms in place to ensure that resources are used in the most efficient manner and that improvement activity with the HEN member hospitals do not duplicate the activities of other CMS partners, such as the Quality Improvement Organizations. These contractors are required to provide documentation of their work, and specific actions they are taking to prevent duplication of effort.

Senator John D. Rockefeller

Questions for the Record:

Today, CHIP is the source of health care for over 37,000 West Virginians and over 8 million children and pregnant women nationwide. Unfortunately, funding for this program is set to end on September 30, 2015.

Even with the Affordable Care Act, the end of CHIP would mean no affordable health options for at least 2 million children and the end of a program that is specifically designed to address the unique health care needs of children and pregnant women.

I am committed to seeing the CHIP program continue past next year. States planning their budgets and families who rely on CHIP need certainty.

25. Do you believe that CHIP, which was created based on the findings of the 1991 National Children's Commission report, remains an essential program for children, and is the President committed to continuing it beyond next year?

Answer: The Administration remains committed to providing affordable, comprehensive coverage for children covered by CHIP, and we look forward to working with Congress to ensure their coverage.

In this Congress, I re-introduced my Medicare Drug Savings Act. This bill will require prescription drug manufacturers to offer rebated pricing for dually eligible beneficiaries in Medicare and Medicaid, just as they did prior to the implementation of Medicare Part D in 2006.

I am pleased to see that the President has included a similar proposal in his budget again this year. According to the Congressional Budget Office, my bill would reduce the deficit, saving taxpayers an estimated $141.2 billion over the next ten years.

Since Part D went into effect, the pharmaceutical industry has received windfall profits, largely at taxpayer expense. Correcting this, simply makes sense.

26. What other steps is the Administration taking to promote more sensible taxpayer spending on pharmaceuticals and better access to life saving treatments that can be financially out of reach for many families?

Answer: The Administration is taking several steps to improve the Medicare Part D program, which has high beneficiary satisfaction, improving quality of care, and low premium growth. Efforts to promote greater transparency, to reduce fraud, to simplify the benefits for beneficiaries, and to reduce the costs of the program are underway, and CMS plans to finalize several proposals related to consumer protections (e.g., ensuring access to care during natural disasters), anti-fraud provisions that have bipartisan support (e.g., strengthening standards for prescribers of prescription drugs), and transparency (e.g., broadening the release of privacy-protected Part D data) after taking into consideration the comments received during the public comment period on its proposed rule.

There are few things as important to me as the health and safety of our coal miners. The Black Lung Clinic Grants Program is a vital resource for miners in my state who need treatment for this debilitating and deadly disease.

This year, the Health Resources and Services Administration (HRSA) imposed a new requirement that will prohibit any single applicant from receiving more than $900,000, regardless of the merits of the application or the number of miners who would be served.

What concerns me most is that the State of West Virginia is the only applicant in the country who would be impacted by this new cap. As a state with one of the highest rates of Black Lung disease, this arbitrary cut in funding is unacceptable.

At the hearing, I very much appreciated that you expressed a willingness to work with me to resolve this issue, and also your belief that Black Lung clinics in my state probably do need more funding under the program.

As a follow up to our conversation at the hearing, I would appreciate responses to some additional questions I have on this matter:

27. Please explain in detail the reasoning for the new funding cap as well as the tiered-based funding structure; how those requirements support the purposes of the Black Lung Clinic Grants Program; and whether those requirements adequately meet the needs of grantees under the program.

Answer: In previous years, HRSA held a limited competition for the Black Lung/Coal Miner Clinics Program, which was only open to existing grantees. While historically states have been awarded the same amount, funding awards were always subject to a competitive selection process where not all applicants were guaranteed a funding or a specific amount of funding.

The new funding strategy for the Black Lung Clinics Program was designed to better allocate funding based on the growing prevalence of coal worker's pneumoconiosis (CWP) nationally. According to a report developed by the National Institute for Occupational Safety and Health (NIOSH) in 2011, CWP is rising nationally. The overall CWP prevalence among coal miners declined from 11.2 percent between 1970 and 1974 to 2.0 percent between 1995 and 1999. However, since 2000, the prevalence of CWP has increased to 3.3 percent and continues to rise.

The new funding strategy for the program includes tier-based funding awards based on national data on the number of mines and miners, projected service levels, and an effort to distribute funding based on growing need. The Office of Rural Health Policy, which administers the program, designed these tiers to help ensure that applications from a broad range of areas have the potential to receive support with available resources. The tiers apply only to individual applicants and not the total number of applications from a state.

The strategy is supported by the authorization of the Black Lung Clinics Program. The statute states that "any State or public or private entity may apply for a grant" and that the "Secretary shall award grants, taking into account the number of miners to be served and their needs; and the quality and breadth of services to be provided."

28. Please provide the details of outreach that HHS and HRSA did to grantees to make them aware of these specific changes to the program, including information about when grantees were first notified that a new tiered system would be implemented along with an overall funding cap of $900,000 per grantee.

Answer: The Office of Rural Health Policy announced in September 2012 that a new approach for the Black Lung/Coal Miner Clinics Program would be implemented beginning in FY 2014. Outreach and education efforts over the past 18 months are detailed below:

- April- June, 2012: Grantees given an opportunity through the Department of Labor (DoL) ePolicyWorks to share their thoughts on ways to align the program with the regulations. ePolicy Works, launched by DoL's Office of Disability Employment Policy (ODEP), is a Web-based approach to policymaking that engages citizens and stakeholders in new and innovative ways.

- July 19, 2012: Sought input from Debbie Wills (Valley Health – West Virginia) regarding compensation counseling aspects of new funding opportunity.

- September 2012: During the September Black Lung Clinics Grantee Meeting, HRSA let grantees know that there would be changes to the program and gave attendees an opportunity to provide feedback. There were no comments. West Virginia representative was in attendance.

- December 2012: Black Lung Coalition president and members met with HRSA staff.

- January 3, 2013: HRSA sent out an email to grantees regarding changes to the Funding Opportunity Announcement (FOA). Grantees were also notified that they would be given a one-year extension at existing funding levels to give HRSA time to collect information and make the necessary changes.

- March 11, 2013: HRSA met with voting members of the Black Lung Coalition in Washington, DC to talk about the program, measures and the new grant guidance. Provided the Black Lung Coalition an opportunity to provide feedback, and HRSA heard from only a couple of the members on the clinical aspect of the program. West Virginia representative was in attendance.

- April 12, 2013: HRSA notified grantees of a Federal Register Notice (FRN) regarding the one-year extension of the current funding cycle in order to more closely align program with existing data from NIOSH and DoL, as well as the regulations.

- July 1, 2013: HRSA solicited input from grantees on the notion of different levels of funding based on service level. They were given 10 days to respond. HRSA received feedback from several grantees.

27. As a result of the newly established $900,000 cap on grants for any one applicant, two entities in the State of West Virginia have applied for separate grants. It is my hope that both grants will be awarded in amounts sufficient to prevent an extremely large reduction in funding, as would be experienced under the $900,000 cap. However, if both applications cannot be funded under the guidelines of the program, given the significant need for these resources in West Virginia will HHS consider waiving or increasing the cap?

Answer: An Objective Review Committee (ORC) will score each application based on the criteria in the funding opportunity announcement (FOA), including the number of individuals diagnosed with Black Lung disease in the service area in comparison to the overall population. Depending on the quality of the applications submitted, the State of West Virginia could receive funding below, at, or above prior levels. In order to ensure that applicants received substantial time to respond to the FOA, the deadline for receiving applications was extended. The Objective Review Committee will begin to review applications in early May 2014 and funding awards will be made in July 2014. At that time, HRSA will be able to determine the number of grantees, and funding amounts that will be allocated.

As you know, the United States faces a health care provider shortage in many rural and densely urban areas.

This shortage impacts whether and when West Virginians can see a provider. The shortage is particularly acute in primary care, mental health services and certain "high need" specialties. I was pleased to see both additional funding for the National Health Service Corps as well as Graduate Medical Education slots targeted at primary care and high need specialties.

28. Please tell us more about how HHS plans to identify "high needs" specialties and whether you anticipate mental health specialties to be among that group.

Answer: The Targeted Support for GME program will support the training of 13,000 physicians over the next ten years. While the program will focus on supporting the training of primary care physicians, it may also support the training of residents in high-need specialties. This approach echoes recommendations from a June 2010 Medicare Payment Advisory Committee (MedPAC) report, which stated that the new residencies should be driven by future workforce needs with a focus on new systems of efficient, high-quality, and high-value, rather than just projecting needs based on current patterns of care. Decisions about the type of physicians supported by this program will be made following research and analysis by entities like the Council on Graduate Medical Education, HRSA's National Center for Health Workforce Analysis, and other experts in the field.

I was pleased to see in the President's budget efforts to address the growing epidemic of prescription drug abuse.

While prescription drug abuse is a nationwide problem, it is a particular challenge in my home state of West Virginia. The additional funds in the President's proposed budget for both the prevention and treatment of prescription drug abuse should make a real difference in efforts to address this epidemic. However, the National All Schedules Prescription Electronic Reporting (NASPER) program has gone unfunded for four years.

29. Without funding for NASPER, how does HHS plan to monitor prescription drug use, without funding for this effective and targeted program?

Answer: The National All Schedules Prescription Drug Electronic Reporting program supported investments in state prescription monitoring programs. HHS will continue to monitor prescription drug abuse through several surveys, data sources, and ongoing efforts in coordination with other federal partners. Key to these efforts is the SAMHSA-funded National Survey on Drug Use and Health (NSDUH). NSDUH is the nation's primary source for information on the incidence and prevalence of substance use and mental illness and related health conditions. NSDUH's funding to reach and survey approximately 70,000 people across the United States and to provide analysis was $56 million in FY 2013, $49 million in FY 2014, and $54 million in the FY 2015 President's Budget. In addition, SAMHSA funds the Substance Abuse Prevention and Treatment Block Grant to fight the abuse of prescription drugs, including through ongoing state data collection and analysis.

Beginning in FY 2012, SAMHSA has also identified prescription drug abuse as a top national prevention priority under the Strategic Prevention Framework. In FY 2015, the President's Budget includes an additional $10 million within SAMSHA in this program for funding for a new effort titled Prescription Drug Abuse and Overdose Prevention. This program will provide funding for the prevention of prescription drug misuse and abuse in high priority age groups (including young and middle-aged adults) and populations through education and other prevention strategies. This effort will be in coordination with a $16 million initiative in CDC to expand its Core Violence and Injury Prevention Program to help states with a high burden of prescription drug overdose focus on high-risk prescribing and high-risk patients. SAMHSA also partners with the National Institute on Drug Abuse to further develop the evidence base to support these prescription drug abuse efforts, and the HHS Office of the National Coordinator of Health Information Technology on standards alignment for interoperability among state prescription monitoring programs, electronic health records and health information exchanges.

I greatly appreciate the President's allocation of additional funds for the Centers for Disease Control and Prevention (CDC). The CDC has long been an important resource for West Virginians. We are one of a few states that participate in all of the CDC's prevention programs, and this year, we had the unfortunate need to rely upon the CDC's emergency response teams. We need robust funding for institutions like the CDC. While overall funding for the CDC is increased in the President's budget, the CDC's discretionary funding is lower than in years past.

30. How can you keep this reduction in discretionary spending from limiting the Agency's ability to respond to disasters ranging from infectious disease outbreaks to chemical spills like the one in West Virginia?

Answer: CDC has unique national capacities and employs many of the world's leading public health experts– but needs strong counterparts in state and local agencies – where your constituents live, and where outbreaks happen. To be close to the ground and respond quickly, we place special emphasis on a robust network of health agencies across the US. In fact two thirds of the funding CDC receives actually goes back to the States by supporting state and local health departments and grantees. While the fiscal environment remains restrained, CDC works 24/7 to ensure every dollar it is appropriated by Congress is used to its fullest potential when responding to disasters, outbreaks, communicable and non-communicable diseases and providing the nation's health data to all Americans. The FY 2015 budget request establishes investments in key programs to respond to disasters and disease outbreaks, proposes strategic new investments, and identifies some targeted reductions. CDC has streamlined our administrative operations, contracts, and business services, and continues to look for innovative ways to maximize all of the funding we receive to ensure we can respond to disasters and outbreaks in a timely and effective manner.

Secretary Sebelius, over the past two years, I have been in close contact with you and CDC officials regarding the need to preserve the unique mine-safety research capabilities of the Lake Lynn Experimental Mine and Lab. Last year, the National Institute of Occupational Safety and Health (NIOSH) vacated the government-leased Lake Lynn property due to the inability to reach a purchase agreement with the site's landowner. Last spring, I was very encouraged when NIOSH informed my office that CDC/NIOSH had entered into a contract to define the requirements for a new facility to replace the research capacity lost at Lake Lynn and had begun working with GSA to develop and issue a solicitation for site/mine acquisition.

I am seriously concerned that the President's FY 2015 HHS budget recommends "redirecting existing resources intended for a new mine safety research center to support other CDC facility requirements." This abrupt reversal is inconsistent with congressional directives included in the FY 2014 Omnibus Appropriations bill. I have five questions related to this issue:

31. Please provide me a detailed accounting of the agencies activities to date to replace the Lake Lynn Experimental Mine and Lab, including the estimated costs for a new facility and the level of prior-year funding that CDC has on hand.

Answer: Mine safety research at the Lake Lynn site has not been conducted since 2008 when the roof collapsed. After vacating the Lake Lynn site in 2012, CDC conducted a number of exploratory activities to replace the facility at Lake Lynn – including awarding a contract to develop the criteria required for a replacement site and facilities. Although CDC has approximately $14 million set aside for the replacement of Lake Lynn from funds appropriated by Congress in prior years, the cost to purchase and build a new site is estimated at close to $65

million. Because the $14 million on-hand is insufficient to cover the full cost of acquiring and developing a new site, and it is not likely under current fiscal constraints that CDC will obtain the funding necessary to fully replicate the site, the Administration has decided not to continue to pursue a replacement site at this time.

The funding available for a replacement mining research facility was originally appropriated in FY 2009 for acquisitions and construction projects that are now complete. Mine safety research remains an occupational research priority for CDC. NIOSH will continue to carry out research projects in the areas of mine explosion, dust exposure and fire suppression as far as they can be taken in a laboratory setting.

32. CDC's budget justification insinuates that the replacement of Lake Lynn is not needed because mine safety research including underground research, tunnel safety, and mine rescue is conducted at other facilities in the United States. Please identify those "other" facilities and elaborate on their ability to conduct the large-scale underground fire and mine explosion testing and research that was conducted at the Lake Lynn lab.

Answer: Mine safety research at the Lake Lynn site has not been conducted since 2008 when the roof collapsed. This underground facility was primarily used for studies and research on mine explosion, mine seals, mine rescue, ventilation, diesel exhaust, new health and safety technologies, ground control, and fire suppression. With the closure of the Lake Lynn Experimental Mine (LLEM), NIOSH will continue to carry out research projects in the areas of mine explosion, dust exposure and fire suppression as far as they can be taken in a laboratory setting,. Virtual reality technologies at the Pittsburgh Research Laboratory are being used for training of mine rescue teams and for development of mine rescue operation procedures. However, with the closure of the LLEM and the FY 15 President's budget policy that funding is not available for purchase of a replacement, approximately 20 other research studies requiring large full-scale mine explosion testing, coal dust inerting studies and research for testing in-place refuge alternatives are on hold.

33. Please identify the "other CDC facility requirements" to which the Administration would redirect the prior-year Lake Lynn funds.

Answer: The other CDC building and facility requirements are for repairs and improvements projects, including NIOSH facilities requirements, that address needs in the areas of fire and life safety, security, and maintaining our Condition Index of at least 90 percent, Currently, CDC has more than $35,000,000 in pending projects.

It is my understanding that the owner of the Lake Lynn property may now be interested in selling. Although the asking price may well exceed the appraised value, it may be a fraction of the cost and time to construct a new replacement facility. In light of budget constraints and the pressing need for this line of mine safety research, I would like the

Administration to re-explore the purchase of the Lake Lynn site in PA and provide me with a follow-up report no later than May 31, 2014.

34. Beyond re-opening sales negotiations with the landowner of the Lake Lynn property, what are the other low-cost options that the Administration could explore to acquire the site?

Answer: There would be many considerations before CDC could fully evaluate this as an option, including:

- CDC/NIOSH vacated the property in 2012. We are unaware of the current condition of the property, and whether the research facility could be reopened.
- The FY 15 President's budget decision was based on the assumption that sufficient funding would not be available for a replacement facility. We have no information on a potential LLEM sale price, nor any current cost estimate for repairs needed to reopen the LLEM research mine. Without this information, it is impossible to evaluate whether this is a viable option at this time.

Access to primary care is critical to maintaining the health of a population, especially in states like West Virginia where prevention and early intervention can significantly reduce the burden of chronic disease. The Medicaid payment bump for primary care, which brings Medicaid payment for primary care services up to at least 100 percent of the Medicare Part B physician rates for the same services, is an effort to encourage the treatment of our most vulnerable populations.

35. How many providers in total, and by state, are receiving enhanced payments as a result of this policy? At what cost annually? Also, has the policy been around long enough to have a demonstrable impact on increasing access to primary care or is more time needed?

Answer: We agree that primary care is critical and the increased payment rates helps recognize the important role of primary care and preventive services by better rewarding physicians for providing this care. We are continuing to evaluate the program to assess the impact on access, providers, as well as cost to the Medicaid program.

Senator Maria Cantwell

Questions for the Record:

Graduate Medical Education

Secretary Sebelius, as I'm sure you agree, the coverage expansions we are achieving through the Affordable Care Act underscore the need to train and equip our health care workforce, especially in rural and underserved areas like much of my state. The

Association of American Medical Colleges (AAMC) has recently projected a shortage of more than 90,000 physicians by the year 2020.

This physician shortage is even worse in my state: with the exception of Western Washington, we have physician per population ratios that are well below the national average.

So, I appreciate that the President's budget includes $14.6 billion for increased investments in the health care workforce over the next decade. In particular, the President's budget proposes $5.2 billion over ten years for a new program, Targeted Support for Graduate Medical Education (GME) focused on preventive and ambulatory care.

This program would award competitive grants to teaching hospitals, children's hospitals, and other community-based providers. I am pleased that, through this program, the Administration has put a focus on preventive and ambulatory care in Graduate Medical Education.

I understand that the program would incorporate two existing Graduate Medical Education programs: the Children's Hospital Graduate Medical Education program and the Teaching Health Center Graduate Medical Education program.

36. Under this program, what standards will guide your determination of which entity receives an award, and how will you administer grants to achieve the Administration's stated goals of supporting ambulatory and preventive care?

Answer: The competitive process for the Targeted Support for GME Program, including the criteria and standards for making awards to applicants, is currently in the preliminary stages of development. The new program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, including in rural and underserved areas. Programs will need to demonstrate that they provide diverse training experiences that will help ensure that we are training future physicians in the settings where we know patients get the bulk of their care, as well as being trained in the models of health care delivery that are most effective.

37. Under this proposal, how will your Department ensure that we maintain our investment in children's and primary care Graduate Medical Education?

Answer: The Targeted Support for GME program will support the training of 13,000 physicians over the next 10 years. The focus of this program will be in primary care. Additional high-need specialties may also be supported. The program includes a $100 million set-aside for 2 years to be distributed to children's hospitals graduate medical education (CHGME) program using the existing CHGME formula to support the current residency training programs, including pediatric subspecialties and other types of specialists who may be presently supported. This is $12 million more per year than prior budget requests, places the program on the mandatory side of the budget

and provides a two-year commitment to children's hospitals as opposed to year-by-year discretionary appropriations. Children's hospitals will not be limited to the $100 million set-aside as they may also apply for funding through the Targeted Support for GME competition process

Indian Health Service Contract Support Cost Claims

I am pleased that the Indian Health Service has requested an increase of nearly $30 million for a total request of $617. 2 million, which your Department claims will cover all Contract Support Costs for FY 2015. However, as you know, there is a huge backlog estimated to be at least 1,200 claims against the IHS for failure to fully pay Contract Support Costs in past years. Although the actual estimated $2 billion in claims will be paid from the Justice Judgment Fund, your Department must pay for the process to settle the claims.

Last month in a budget hearing before the Indian Affairs Committee, IHS Director Dr. Roubideaux stated that the Department was making progress on resolving past contract support cost claims. But that does not seem to be the case. Of the estimated 1,200 current Contract Support Cost claims only 200 settlement offers have been made and only 50 have actually been settled.

We've discussed this issue many times with the Administration over the past twenty months. I think the fact that only 50 claims have been settled in nearly two years is appalling. For years, the federal government has refused to pay full contract support costs. Now, after forcing tribes to take their case all the way to the Supreme Court, which they won twice, we're now forcing tribes to wait years before they even get an offer.

38. Can you tell me with any certainty when these claims will all be resolved?

Answer: IHS' goal is to get offers out this year on most of the claims that are currently pending. There are approximately 96 claims that have been formally settled with nine tribes. An additional 85 offers have been accepted by 15 Tribes and are in the process of settlement. The total settlement amount for these 181 claims that have been formally settled or are in the process of settlement is over $289 million.

39. I understand that the Department is just trying to assure the claim amounts are accurate. But, are we not wasting more federal tax dollars fighting these claims than we would spend by relying on the estimates your Department sends to Congress every year? These estimates are certified and any adjustments to the claims could be made in months rather than years.

Answer: IHS complies with the multi-step process required by the Contract Disputes Act (CDA), and accordingly it must analyze each claim individually to determine the amount of Contract Support Costs (CSC) owed to a Tribe for each contract term. Shortfall reports provided to Congress include estimated overall aggregate CSC need at a particular point in time and do

not provide final data. At the time of preparation of the report IHS often does not have, for example, the final indirect cost rate negotiated by a Tribe with its cognizant agency or the pass-throughs and exclusions required by that indirect cost rate. The shortfall reports are based on the amount of IHS funding paid to a Tribe and information available to IHS at the time; the reports do not reflect the amount owed under any particular contract.

In IHS's view, this effort to identify the proper CSC amount through the settlement process is a permissible use of taxpayer dollars. . In addition, the IHS has been working with Tribal representatives on its IHS CSC Workgroup to ensure CSC estimates are updated over time to ensure consistent and fair estimates. At the time of settlement discussions, updates to the estimates in a collaborative manner with Tribes promote our ongoing relationship. IHS continues to work to find ways to streamline the claims settlement process.

40. With the delay in settling these claims, what kind of legal costs is your Department incurring? I understand that there was a recent attempt to get more contract attorneys to help settle these claims. How are those attorneys being paid for?

Answer: IHS is using available resources to resolve claims for unpaid CSC with a primary focus on speedy resolution whenever possible. These resources include FY 2014 funds and resources from the Department of Health and Human Services' non-recurring expense fund allocated to increase staff to help accelerate the CSC claims settlement process.

IHS believes that the Agency and Tribes working together to resolve the claims will have the most benefit for our ongoing relationship. IHS has improved internal business practices related to the CSC claims settlement process and is consistently reviewing methods to enhance collaboration and streamline the process while maintaining a foundation of assuring a fair and consistent approach with all Tribes.

Senator Robert Menendez

Questions for the Record:

Combating Autism Reauthorization

As you know, the Center for Disease Control and Prevention (CDC) recently released a report showing a 30 percent increase in the prevalence of autism, with 1 in 68 children age 8 being diagnosed with an autism spectrum disorder. My state of New Jersey was shown to have the nation's highest prevalence with 1 in every 45 children receiving a diagnosis by the age of 8.

With the Combating Autism Act scheduled to sunset at the end of the current fiscal year, I have partnered with my friend Senator Enzi to reauthorize this important legislation and

ensure the law's programs will continue our efforts to better understand autism and support individuals with autism and their families.

41. Can you provide a detailed description of the federal autism efforts currently authorized by the Combating Autism Act?-

Answer: In February 2014, HHS submitted a report to Congress as required by the Combating Autism Act of 2006 (CAA) and the Combating Autism Reauthorization Act of 2011 (CARA) describing federal agency efforts on autism spectrum disorder (ASD), including information from nine agencies within HHS, and the Department of Education, the Department of Defense, the National Science Foundation, and the Environmental Protection Agency. This comprehensive report contains detailed information about ASD research and services programs supported by the Federal agencies named above, including activities undertaken to implement provisions of the CAA and CARA, to meet the needs of people on the autism spectrum and their families.

The report includes information on each agency's ASD-related expenditures and mission area, as well as descriptions of activities spanning biomedical and services research, public health activities, education initiatives, early screening, diagnosis and intervention services, provider training, healthcare delivery, social supports, and vocational training. The report also provides summaries of activities addressing several specific areas outlined by Congress in the CAA, including the prevalence of ASD, the average age of diagnosis, effectiveness of outcomes and interventions, and adult services and supports. The current report, the Report to Congress on Activities Related to Autism Spectrum Disorder and Other Developmental Disabilities Under the Combating Autism Act of 2006 and Combating Autism Reauthorization Act of 2011 (FY 2010 - FY 2012), covers Federal activities in fiscal years 2010-2012. The first edition of this report, the Report to Congress on Activities Related to Autism Spectrum Disorder and Other Developmental Disabilities Under the Combating Autism Act of 2006 (FY 2006-FY 2009), was delivered to Congress in 2011 prior to the last reauthorization of the CAA. Both reports, prepared by the NIH Office of Autism Research Coordination on behalf of the Office of the Secretary, HHS, in conjunction with the Department of Education and other Federal agencies, are posted on the Interagency Autism Coordinating Committee website at www.iacc.hhs.gov. Hard copies can be obtained by sending a request to iaccpublicinquiries@mail.nih.gov.

42. What would be the impact on these programs in the event Congress fails to reauthorize the law before October 1, 2014?

Answer: Due to the sunset provisions in the statute, if the law is not reauthorized, HHS would not be able to continue some of its activities under this authority. HHS may utilize other statutory authorities that would allow it to continue some, but not all, of these public health activities, so long as appropriate funding is provided.

New Jersey's Imputed Rural Floor

One of the unique issues facing hospitals in my state is the constant threat of having the

Center for Medicare and Medicaid Services (CMS) pull funding out of the system by not renewing the imputed rural floor policy. I say unique because New Jersey is one of only two "all-urban" states under Medicare (along with Rhode Island). This means that hospitals in New Jersey are prohibited from benefiting from any of the rural-only payments available to hospitals in every other state in the country. As such, the imputed rural floor provision is a vitally important policy that allows hospitals in New Jersey to continue providing the highest-level care possible to patients throughout the state.

I have attached a copy of the New Jersey Congressional delegation's letter to CMS Administrator Tavenner urging this policy be made permanent, or at least continued until Congress enacts comprehensive reforms to the Medicare wage index system.

43. Can you provide reassurances that the fiscal year 2015 Inpatient Prospective Payment System (IPPS) rule will include a permanent or long-term extension of the New Jersey imputed rural floor policy?

Answer: CMS is currently working on the IPPS proposed rule for FY 2015, which we anticipate issuing later this month. We will consider your support to make the Medicare imputed floor wage index provision permanent as we formulate the proposed rule. We typically present the precise impact of our proposed wage index policies in each rule, and we welcome public comment on those wage index proposals.

<u>Spouses as Business Partners – Access to Group Plans</u>

Prior to plan year 2014, New Jersey's state insurance regulations allowed a sole proprietor of a business and his or her spouse-employee to be eligible for a small group health plan even in the absence of any other "bona fide" employees. Starting this year, however, these couples are no longer eligible for small group plans and are instead required to purchase coverage on the individual market. While it is true that these couples can, for the first time, access qualified health plans through the state's federally facilitated Marketplace, I have heard about potentially substantive differences in the individual market plans compared to the previous small group plans (e.g. to plans' of out-of-network and prescription drug coverage). It is important to note that similarly situated business partners who are not married are still capable of purchasing small group coverage.

44. What are the specific regulations and policies that led to a marital status-based distinction in eligibility for small group plans? Since both spouses are employees in the same small group of two, how is the impact on issuers (e.g. on risk indexing or guaranteed availability) different than if the two employees were not married?

Answer: The definition of "employee" in Public Health Service Act section 2791(d)(5) refers to the definition of "employee" as defined in section (3)(6) of ERISA which is administered by the Department of Labor. Department of Labor regulations do not consider a sole proprietor and his/her spouse to be employees for purposes of group health coverage. Therefore, health coverage of an owner of a business and/or his/her spouse with no other employees is not

considered to be a group health plan and thus the owner would not be eligible to purchase a health insurance plan in the small group market. However, if an owner employs an individual who is not a spouse and would otherwise qualify as an employee, this example would be considered a group of one and the owner (and spouse) would be eligible to purchase health insurance in the small group market for themselves and the one employee.

The Affordable Care Act redefined a small group employer as consisting of 1-100 employees upon enactment of the law, with state option to substitute 50 employees instead of 100 for plan years 2014 and 2015.

45. What steps could be taken to continue allowing New Jersey spouses in a sole proprietor business partnership access to small group plans in plan year 2015?

Answer: The definition of "employee" in Public Health Service Act section 2791(d)(5) refers to the definition of "employee" as defined in section (3)(6) of ERISA which is administered by the Department of Labor. Department of Labor regulations do not consider a sole proprietor and his/her spouse to be employees for purposes of group health coverage. The Department of Labor has jurisdiction over ERISA. To categorize a sole proprietor and his/her spouse as employees for purposes of group health coverage will require a change in the Department of Labor regulations implementing ERISA.

46. In how many states was the previous state-level definition of "employee" preempted by the federal definition, which doesn't allow for a spouse to qualify as a bona fide employee?

Answer: CMS does not track this information.

Senator Sherrod Brown

Questions for the Record:

Medicaid Primary Care Parity

A recent study published in the Journal of the American Medical Association (JAMA) Internal Medicine found that only 57.9% of individuals claiming to have health insurance under Medicaid were able to schedule an appointment with a primary care physician compared to the 84.7% of individuals with private health insurance. While the Affordable Care Act (ACA) has helped expand health insurance coverage to millions of Americans, the next step in health reform is ensuring that beneficiaries have access to providers, regardless of their source of coverage. There must be a sufficient workforce to ensure that all individuals, regardless of their community or socioeconomic status, have access to health providers.

I applaud Administration's commitment to extending enhanced primary care reimbursements for Medicaid providers as reflected in the President's FY 2015 Budget, including nurse practitioners and physician assistants, but remain concerned that a one year extension of the Medicaid primary care parity provision is not sufficient to incentivize more primary care providers to treat Medicaid patients. Prior to the ACA, Medicaid paid physicians an average of 58% of Medicare reimbursement rates for primary care. As noted in the Republican Budget Committee Report *The War on Poverty: 50 Years Later*, this discrepancy in payment has historically led to a lack of primary care providers who treat Medicaid subscribers.

The Congressional Budget Office (CBO) estimates that about 8 million people will join Medicaid in 2014, which is likely to exacerbate the lack of Medicaid primary care providers. Extending parity on a year-by-year basis will not incentivize additional providers to treat Medicaid beneficiaries; a longer extension is necessary.

47. Will the Administration extend this enhanced Medicaid reimbursement for primary care permanently?

Answer: The President's FY 2015 budget proposes to extend the program through December 31, 2015.

48. Why are other critical primary care providers, such as Ob-Gyns, excluded?

Answer: The statute specifies that only services provided by physicians with a primary specialty designation of family medicine, general internal medicine and pediatric medicine are eligible for higher payment. CMS interpreted the statute through regulation to extend to subspecialists within those categories and to practitioners working under the direct supervision of those physicians. However, the statute precluded CMS from extending higher payment to other physicians, such as OB/GYNs.

49. Are there codes other than emergency room codes that should be excluded from this provision to better target primary care?

Answer: We will continue to monitor the program for improvements that will help better target primary care.

50. Will the Administration publish a report on the effectiveness of this provision, to help determine the best way to incentivize Medicaid providers going forward?

Answer: The implementing regulations include a requirement for states to supply CMS certain information necessary to evaluate the effectiveness of this provision. In the future, CMS plans to make this information available on the Medicaid.gov website.

National Institute for Occupational Safety and Health (NIOSH)

As stated on p. 36 of the *Proposed FY2015 L-HHS Budget in Brief*, the mission of the Centers for Disease Control and Prevention's (CDC) NIOSH is to "prevent work-related injury, illness, and death." NIOSH's efforts on worker safety and worker health across all sectors of the economy are essential to American competitiveness and allow for prevention of work-related safety and health risks that would otherwise take a great toll on workers and their communities.

While I appreciate the Administration's attempt to balance budgetary priorities, targeted reductions to the Education Research Centers (ERC) under NIOSH are not the right way to prioritize.

51. How can NIOSH, and specifically the ERCs within NIOSH, continue to provide academic and research training programs in the core occupational safety and health disciplines, as well as provide education and outreach programs to prevent injury and disease, with $52 million less than last year's funding?

Answer: The ERC program is proposed for elimination given the resource-constrained environment. Originally created almost 40 years ago, the ERC program addressed the limited number of academic programs focusing on industrial hygiene, occupational health nursing, occupational medicine, and occupational safety. The ERCs' reach and impact have grown substantially across the nation since the program's inception, increasing awareness of the importance of coursework specializing in these areas. CDC will continue to provide scientific and programmatic expertise to the ERCs as requested.

52. In addition, most of NIOSH's facilities are more than 60 years old; how does the Administration expect the Institute to sustain its important research related to ensuring workplace safety and worker health for America's 155 million workers when the very buildings NIOSH employees work in pose potential health risks themselves?

Answer: NIOSH facilities are included in CDC's Master Facility Plan and are prioritized for renovation and replacement along with other CDC facility needs. Over the past decade, CDC has conducted several evaluations of the Cincinnati facilities (Taft, Taft North, and Hamilton) focusing on present and future mission requirements, the long term viability of the current buildings, and options for accommodating NIOSH research activities in the future. Common themes in these evaluations indicate that the current facilities have limited viability going forward for reasons including both the age and condition of the buildings, and the capacity to accommodate the research activities. In response to these deficiencies, CDC has prepared a Program of Requirements (POR) and a Project Development Study (PDS) to support a solicitation and acquisition of a new site with existing facilities, available on the Cincinnati open real estate market that would meet the NIOSH facility requirements with limited renovation and/or construction. Similarly, NIOSH plans to evaluate the Pittsburgh site, but has not yet initiated planning for any modifications.

Children's Hospital Graduate Medical Education (CHGME) Programs

During the hearing, Senator Casey brought up a critical issue related to CHGME programs. While I commend the President for everything he has done to help bolster our country's healthcare workforce, I believe more can be done to ensure the future of providers who choose to focus on children's health. CHGME ensures continued medical training for professionals treating children and has provided funding to hundreds of children's hospitals across the country in the past, including seven Ohio children's hospitals. We cannot afford to let CHGME disappear.

Children's healthcare requires doctors and hospitals that specialize in pediatrics. CHGME funds help to ensure that hospitals have the resources necessary to train doctors and equip them with the tools to treat children. Despite the fact that President Obama signed a reauthorization of the CHGME program into law just last week, I remain concerned that the FY15 budget does not prioritize GME funding for children's hospitals.

53. How can the Administration help ensure that financing for CHGME and the new competitive grant program detailed in the proposed budget provides sufficient financing directed toward training more pediatricians and pediatric specialists?

Answer: The Targeted Support for GME program will continue to support graduate medical education in children's hospitals. The program includes a $100 million set-aside for 2 years to be distributed to children's hospitals using the existing CHGME formula to support the current residency training programs, including pediatric subspecialties and other types of specialists who may be presently supported. This is $12 million more per year than prior budget requests, places the program on the mandatory side of the budget and provides a two-year commitment to children's hospitals as opposed to year-by-year discretionary appropriations. Children's hospitals will not be limited to the $100 million set-aside as they may also apply for funding through the Targeted Support for GME competition process.

54. What is the administration's thought process behind proposing the elimination of the appropriation for CHGME?

Answer: It is proposed that the CHGME program will be integrated into the new, competitive community-based Targeted Support for GME program which will expand residency slots, with a focus on ambulatory and preventive care in order to advance the Affordable Care Act's goals of higher value health care that reduces long-term costs. Current CHGME grantees will be eligible to compete for these grants, and no less than $100 million of resources in the first and second years of the program would be specifically allocated to children's hospitals that have been eligible for funding under the CHGME program.

55. How can we ensure this targeted support for GME program funds children's hospitals and training programs at a level sufficient to care for our nation's children?

Answer: The Targeted Support for GME program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, as well as care provided by an integrated team of clinicians. The program will help ensure that we are training future physicians in the settings where we know patients get the bulk of their care, as well as being trained in the models of health care delivery that are most effective. Current CHGME grantees will be eligible to receive funding through this new program, and no less than $100 million of resources in the first and second years of the program would be specifically allocated to children's hospitals that have been eligible for funding under the CHGME program.

Antibiotic Resistance

The CDC's recent report *"Antibiotic Resistance Threats in the United States, 2013,"* conservatively estimates that more than two million people are sickened each year with antibiotic-resistant infections – resulting in at least 23,000 deaths a year. Infections caused by resistant microorganisms are increasingly untreatable, uncontrollable, and deadly, as these infections are able to withstand attack by antibiotics and other standard treatments. Given these dismal statistics, I am pleased that the Administration has proposed an increase in funding to strengthen the federal response to antibiotic resistance (AR) and help combat this public health crisis.

56. I commend the Administration for investing more in the CDC's AR initiative, and I would like to know more about the CDC's plan to combat AR going forward. What is the CDC doing to collaborate with other agencies to help coordinate efforts to combat AR?

Answer: The FY 2015 President's Budget includes a $30 million increase for CDC's "Detect and Protect Against Antibiotic Resistance" Initiative (known as the AR Initiative) as well as a $14 million increase for CDC's National Healthcare Safety Network (NHSN) which will support dramatic expansions in antibiotic use and antibiotic resistance data collection. These proposed funding increases support aspects of the four core action areas that CDC outlined in the AR Threat Report from last fall:

- **Detect** and track patterns of antibiotic resistance.
- **Respond** to outbreaks involving antibiotic-resistant bacteria.
- **Prevent** infections from occurring and resistant bacteria from spreading.
- **Discover** new antibiotics and new diagnostic tests for resistant bacteria.

The AR Initiative lays out a road map for fighting antibiotic resistance by: speeding up detection through a new regional lab network; supporting production of new antibiotics and diagnostics through a new resistant-bacteria bank, preventing infections and improving antibiotic prescribing practices in the community and in healthcare facilities. The AR Initiative is targeting seven antibiotic-resistant threats including:

- ***Clostridium difficile* (*C. difficile*):** causes deadly diarrhea mostly in people who've recently had medical care and antibiotics.
- **Carbapenem-resistant Enterobacteriaceae (CRE):** the so-called nightmare bacteria because they are resistant to nearly all antibiotics and spread easily.
- **Multidrug-resistant (MDR) *Neisseria gonorrhoeae*: causes gonorrhea, a sexually transmitted disease; showing resistance to antibiotics usually used to treat it.**
- **Extended-spectrum β-lactamase-producing Enterobacteriaceae (ESBL):** bacteria one step away from becoming CRE
- **MDR *Salmonella*:** causes about 100,000 illnesses in the US each year; infections that are resistant are more severe.
- **Methicillin-resistant *Staphylococcus aureus* (MRSA):** causes a range of illnesses, from skin and wound infections to pneumonia and bloodstream infections.
- **MDR *Pseudomonas*:** a common cause of healthcare-associated pneumonia and bloodstream infections; some strains are resistant to nearly all antibiotics.

The AR Initiative can have a measureable impact in reducing antibiotic resistance. We project, these investments could result in:

- 50% reduction in healthcare-associated *C. difficile* which will save 20,000 lives, prevent 150,000 hospitalizations, and cut more than $2 billion in healthcare costs;
- 50% reduction in healthcare-associated CRE infections;
- 30% reduction in healthcare-associated MDR pseudomonas;
- 30% reduction in invasive MRSA infections;
- 25% reduction in MDR *Salmonella* infections;
- Nationwide implementation of CDC antibiotic protection tools and improved prescribing in US acute-care hospitals and outpatient settings.
- Increase 10-fold drug susceptibility testing (to see which antibiotics stop bacteria from growing) for high-priority pathogens like CRE.
- Establish a Resistant-Bacteria Bank, a unique centralized collection of samples of resistant bacteria that supports antibiotic and diagnostic development.

The proposed increase for NHSN would support the implementation and uptake of CDC's new antibiotic use and resistance module (AUR). The NHSN AUR module will dramatically expand our knowledge about community, state, and national trends related to antibiotic use (AU) and antibiotic resistance (AR). The use component of the NHSN AUR module will provide standardized facility-specific reporting of antibiotic use which will directly impact facility-specific stewardship programs and inform the national assessment of inpatient prescribing quality. NHSN AU reporting builds on the existing infrastructure being used for the reporting of healthcare associated infections and widespread reporting of antibiotic use data to NHSN would provide unit-specific and facility wide use data that can be used to both target and assess interventions to improve use and can be used for inter-facility comparisons.

The resistance component of the NHSN AUR module will allow facilities to automatically send monthly summary files of electronically-captured antibiotic susceptibility data from hospital laboratories. This approach improves accuracy of data, reduces the work required for facilities to report, and allows for broad-based surveillance of antibiotic resistance across many different

pathogens. When a broad variety and geographically diverse number of facilities are reporting, these data can be used to detect new resistance, to monitor trends including geographical differences in resistance, and to measure the impact of prevention efforts.

CDC is collaborating with several federal agencies in the area of antibiotic resistance and we are continually looking for ways to make the data we collect through AR surveillance efforts available to other agencies and public health authorities to maximize the US efforts to combat AR. The Interagency Task Force on Antibiotic Resistance (ITFAR) provides specific information on what agencies are collaborating on in this area; a full summary of the most recent action plan can be found here. Some highlights of ongoing collaborations include:

- **CMS to collect and report hospital-specific infection rates for two antibiotic resistant threats, MRSA and *Clostridium difficile*.** Hospitals are required to report infection rates to CDC's web-based National Healthcare Surveillance System (NHSN) as part of the CMS inpatient quality reporting program.
- **FDA and USDA to monitor antibiotic resistance in AR threats from food-producing animals (the NARMS program).** This programs monitors antibiotic resistance threats in humans, animals and retail meat products. This program has been critical for monitoring trends, supporting regulatory decisions affecting the use of antibiotics, and also for detection of outbreaks.
- **CDC, FDA, NIH, DoD collaborating on laboratory data of AR threats.** Multiple federal agencies are discussing how best to share lab and genomic data on AR threats across the government to support surveillance, research, and diagnostic development. Among other applications, these data will be used to develop new AR diagnostics for more rapid and accurate detection of antibiotic resistance and to inform site selection for clinical trials to evaluate new drugs to treat resistant infections.
- **NIH to conduct clinical trials for treatment of resistant gonococcal infections.** The results of a recent clinical trial were used by CDC to update new treatment recommendations.

57. I recently re-introduced the *Strategies to Address Antimicrobial Resistance* (STAAR) *Act*, which would strengthen the federal response to AR by reauthorizing the Interagency Task Force on Antimicrobial Resistance (ITFAR) and allowing the CDC to partner with state health departments to implement prevention collaboratives, and to expand public health partnerships through the CDC's established Prevention Epi-Centers work. How could the budget's increase in funding to combat AR bolster the STAAR Act's potential to coordinate a federal response to this public health crisis?

Answer: CDC's proposed increase of $30 million request in the FY 2015 for the new Detect and Protect Against Antibiotic Resistance (AR) Initiative along with its proposed $14 million increase for the National Healthcare Safety Network is consistent with several provisions in the STAAR Act (S. 2236) to combat antibiotic resistance. For example:

AR Laboratories: CDC's FY 2015 AR Initiative is consistent with the STAAR Act provision to establish AR Surveillance and Laboratory Network sites. CDC's FY 2015 AR Initiative will

create five regional laboratories to detect and respond to outbreaks of the most concerning resistant threats and rapidly characterize emerging resistance. The CDC's new regional laboratory network and resistant-bacteria bank will speed up outbreak detection and production of new antibiotics and diagnostics. The new CDC Network will increase susceptibility testing for high–priority bacteria and, as a result of the FY 2014 strategic investment in CDC's Advanced Molecular Detection (AMD), will provide a platform to leverage cutting edge technologies against AR infections. CDC's AR Initiative will also provide funds to establish a new AR Isolate Library, a unique centralized collection of samples of resistant bacteria that will be made available to pharmaceutical companies testing new antibiotic agents and biotech/ diagnostic companies designing new clinical tests.

Regional Prevention Collaboratives: The STAAR Act includes language to support CDC's Regional Prevention Collaboratives. With the additional funding in CDC's FY 2015 AR Initiative, CDC will work with healthcare facilities and large health systems to expand existing Prevention Collaboratives to implement effective evidence-based interventions to stop AR threats in inpatient healthcare settings where the threats are most deadly. The Prevention Collaboratives will engage large health systems to ensure sustainability, improve reach, and extend interventions to long-term care settings, work with healthcare facilities on implementing prevention strategies and standardize communication between facilities.

Antimicrobial use, Antimicrobial stewardship & the CDC Prevention Epi-centers: The STAAR Act includes provisions to measure, benchmark and improve appropriate antimicrobial use and recognizes the economic impact and cost savings of antimicrobial stewardship programs. CDC's FY 2015 AR Initiative will enable CDC to expand and improve antibiotic stewardship programs that evaluate state-to-state variations in antibiotic use to improve outpatient prescribing and educate healthcare providers. The AR Initiative will also fund an Antibiotic Adverse Event Study to evaluate the impact of early pediatric antibiotic use on adverse events later in life. Potential areas of study would retrospectively evaluate the impact of early antibiotic use on obesity, asthma, eczema, allergies, and *Clostridium difficile*. The STAAR Act also includes provisions to pilot and test health care quality measures to help providers, facilities and health systems measure and benchmark appropriate antimicrobial use and collect antimicrobial use and resistance data. CDC's FY 2015 increase for NHSN will be used to extend participation in NHSN's Antimicrobial Use (AU) Module and fully implement the Antimicrobial Resistance (AR) Module to track and analyze those trends and provide national benchmarks to assess antimicrobial use and the severity of antibiotic resistance across facilities. CDC will use also support the development and testing of AU and AR measures for presentation to the National Quality Forum for consideration as national healthcare quality measures. Within the proposed increase in NHSN funding, CDC will also fund additional Prevention EpiCenter research to identify new and better strategies to detect and prevent AR infections.

<u>Medicare Coverage for Post-Hospitalization Care</u>

I appreciate CMS's commitment to Medicare beneficiaries and making sure they receive the benefits they deserve. CMS has been aware of observation stay problems since the 1990s.

CMS's "2 midnight rule" may have been an attempt to help with the issue of counting observation days in the calculation of the 3 day hospital stay requirement for nursing facility post- acute care, but it seems to have made things worse.

58. Do you have other regulatory ideas for dealing with this problem? How will you engage stakeholders in solving the "2 midnight" issue?

Answer: CMS has been actively engaging stakeholders on the issue of when a beneficiary should be admitted as an inpatient ("2-midnight" rule). The 2-midnight rule was intended to provide greater clarity on when an inpatient hospital admission would be appropriately paid under Medicare Part A in order to help reduce uncertainty that might otherwise prompt the excessive use of outpatient observation services. In the calendar year 2013 Hospital Outpatient Prospective Payment System rule, we solicited public comments on potential policy changes we could make to improve clarity and consensus among providers, Medicare, and other stakeholders regarding the relationship between admissions decisions and appropriate Medicare payment, such as when a Medicare beneficiary is appropriately admitted to a hospital as an inpatient. Stakeholders suggested a variety of ways to determine when a patient is appropriately admitted to the hospital as an inpatient but there was no consensus among public commenters.

Upon evaluating the suggestions of stakeholders who requested that we provide more clarity in the definition of 'inpatient' using parameters other than those that we currently use, we recognized that it would be helpful to address what the requirements are for Medicare Part A payment under the inpatient hospital benefit and when a beneficiary should be admitted as a hospital inpatient. Toward that end in the fiscal year 2014 Hospital Inpatient Prospective Payment System (IPPS) proposed rule, we proposed to establish a new benchmark for purposes of the physician or other qualified non-physician practitioner's decision to order an inpatient admission, based on how long beneficiaries are reasonably expected to spend in the hospital Under the proposal, we indicated that, in addition to procedures designated by CMS as inpatient-only, surgical procedures, diagnostic tests, and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when (1) the physician expects the beneficiary to require a stay that crosses at least 2 midnights and (2) admits the beneficiary to the hospital based on that expectation. After considering and responding to many public comments on this issue, we finalized this policy in the FY 2014 IPPS final rule.

CMS has also implemented a transitional period from October 1, 2013 through March 31, 2015 to allow hospitals to adjust to this requirement. The Medicare Administrative Contractors (MACs) will conduct patient status reviews using a probe and educate strategy for claims submitted by acute care inpatient hospitals, long term care hospitals, and inpatient psychiatric facilities for dates of admission on or after October 1, 2013 but before April 1, 2015. MACs are to conduct probe reviews and deny claims found to be out of compliance with the final rule. Based on the results of these initial reviews, MACs will conduct educational outreach efforts. In addition, Recovery Auditors will not conduct patient status prepayment or post payment reviews for claims with dates of admission between October 1, 2013 and March 31, 2015. The

Protecting Access to Medicare Act of 2014 extended this transitional period and the moratorium on Recovery Auditors' reviews until March 31, 2015.

CMS has held a number of Special Open Door Forums about the "2-midnight rule" and inpatient admission medical review criteria. We will continue to have dialogue with provider organizations about this issue. CMS is working with the hospital industry and with MACs to determine if there are any circumstances outside of those already identified as exceptions to the 2 midnight benchmark under which Part A payment would be appropriate for inpatient admissions ordered without a reasonable expectation of a 2 midnight stay.

Senator Robert Casey

Questions for the Record:

The Children's Hospital Graduate Medical Education (CHGME) program has been a major success and has enjoyed broad bipartisan support. It is disappointing that the White House proposes to eliminate funding for CHGME and roll funding for training in children's hospitals into a new program that would have to be created by Congress. Proposing to eliminate support for a current program with a proven track record of success puts at risk the gains that have been made for children's health under CHGME. In addition, the Administration continues to under fund pediatric workforce training. $100 million, while an increase from last year, is still inadequate. The small class of hospitals that receive CHGME, less than one percent of all hospitals, train nearly half (49%) of all pediatricians, including 45 percent of general pediatricians and 51 percent of pediatric specialists. As you know, there are serious national shortages in many pediatric specialties, shortages which the CHGME program has been crucial in helping to address. In some specialties, like pediatric rehabilitation, the CHMGE hospitals train virtually 100% of those providers.

59. Have you considered the likely impact on specialty care from this proposed change?

Answer: The Targeted Support for GME program may fund residencies in specialties where there are high needs to help ensure that the Nation is investing where we have the greatest future workforce needs. This echoes recommendations from a June 2010 Medicare Payment Advisory Committee (MedPAC) report, which said that the new residencies should be driven by future workforce needs with a focus on new systems of efficient, high-quality, and high-value, rather than just projecting needs based on current patterns of care. Decisions about the type of physicians supported by this program will be made following research and analysis by entities like the Council on Graduate Medical Education, HRSA's National Center for Health Workforce Analysis, and other experts in the field.

60. Please explain in detail how with this level of funding we can adequately ensure resources are available to train the specialty pediatric workforce of tomorrow?

Answer: HRSA anticipates that the Targeted Support for GME (TSGME) program will support pediatric training in both children's hospitals and settings other than children's hospitals. Approximately half of pediatric residents receive their training in children's hospitals. The TSGME program includes a $100 million set-aside for 2 years to be distributed to children's hospitals using the current CHGME formula. This is $12 million more per year than prior budget requests, places the program on the mandatory side of the budget and provides a two-year commitment to children's hospitals as opposed to year-by-year discretionary appropriations. Children's hospitals will not be limited to the $100 million set-aside as they may also apply for funding through the TSGME competition process.

61. Very simply: who will treat our kids if we do not invest in CHGME?

Answer: The Targeted Support for GME program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, as well as care provided by an integrated team of clinicians. The program will help ensure that we are training future physicians in the settings where we know patients, including children, get the bulk of their care, as well as being trained in the models of health care delivery that are most effective.

The administration has been instrumental in supporting delivery system reform efforts across the country. As we move our reimbursement system to one that prioritizes value over volume, I am concerned about unintended consequences for patients – in particular low-income, underserved patient. Programs, such as the Medicare Readmissions program, must recognize the added challenge, in the form of both resources and expertise, that serving such populations requires in order to ensure success in meeting quality metrics and improved health outcomes for patients. NQF, MedPAC and others have also suggested these are challenges exist and are worth recognizing.

62. To that end, how is the Department of Health and Human Services contemplating the role of sociodemographics in impacting health and cost outcomes in the context of value-based reimbursement models?

Answer: The outcome measures that are used in many of our programs, such as the Inpatient Quality Reporting program, the Hospital Readmissions Reduction program, and the hospital Value-Based Purchasing program, use risk adjustment methodologies that include clinical risk factors, such as age, comorbid diseases, and indicators of patient frailty. To the extent that socioeconomic factors result in certain patients having a greater severity of illness, these factors should be accounted for in the risk adjustment methodology.

Current policy for risk adjustment policy in CMS quality programs is consistent with prior NQF recommendations. NQF is reexamining the issue of adjustment for socio-demographic factors for particular outcome measures and has recently issued a draft report on this subject. We plan to closely examine NQF's work in this area, review the evidence basis for the preliminary

recommendations, provide input and comments, continue to analyze risk adjustment methodologies, and consider potential refinements as necessary.

63. Are you concerned that providers will steer away from serving patients that present those additional challenges?

Answer: The risk adjustment methodology used in the quality and cost measures, which includes adjustments for severity of illness and comorbid conditions, adjusts for the key variables that are clinically relevant and have a strong relationship with the outcome. To the extent that socioeconomic factors result in certain patients having a greater severity of illness, these factors should be accounted for in the risk adjustment methodology and providers should not have incentives to steer away from these patients. We will monitor new studies about risk adjustment and consider refinements to either measures or payments as appropriate.

Thank you for acknowledging that we needed to provide some relief on the Medicare Advantage from and rolling back some of the changes that were included in the final call letter. I've always appreciated your willingness to work with us on this issue. The Medicare Advantage program continues to grow. More seniors are choosing this option and premiums have fallen by 10 percent. This is good news. We all understand the pressures plans face in the Medicare Advantage pressure and we need to do all we can to protect beneficiary choice, benefits and robust networks. To that end, the industry and Wall Street analysts are still concerned that despite our efforts to allow smooth transitions, some plans will still face reductions in reimbursement levels.

64. Moving forward what steps do you plan to take to help the Medicare Advantage program remain strong?

Answer: The changes to Medicare Advantage announced in the 2015 rate announcement and final call letter set a stable path for the Medicare Advantage program and implement a number of policies that ensure beneficiaries will continue to have access to a wide array of high quality, high value, and low cost options while making certain that plans are providing value to Medicare and taxpayers.

On payments to Medicare Advantage plans, CMS estimates the overall net change to plan payments between 2014 and 2015 to be an increase of 0.4 percent. CMS will implement a new phase-in schedule for the Part C risk adjustment model introduced in 2014 and has refined its risk adjustment methodology to account for the impact of the influx of baby boomers into the program.

To provide greater protection for beneficiaries, in the 2015 contract year, CMS again used its authority to protect Medicare Advantage enrollees from significant increases in costs or cuts in benefits, and, for the 2015 contract year, finalized the permissible amount of increase in total beneficiary cost to $32 per member per month, down from $34 per member per month for the 2014 contract year. Additionally, the final Call letter strengthens tools used to ensure compliance

with established provider access requirements and establishes best practices for Medicare Advantage Organizations to follow when they make significant changes to their provider networks. CMS is also establishing a policy to allow enrollees to switch plans when they are affected by substantial mid-year provider network terminations initiated by their Medicare Advantage Organization without cause.

These steps will help protect beneficiaries and ensure the strength of the Medicare Advantage program into the future.

The President's budget proposes to increase the 60 Percent Rule for inpatient rehabilitation facilities to 75 Percent. An alternative to changing the 60 Percent Rule would be to limit the amount of inpatient rehabilitation facility (or IRF) outlier payments a facility or unit could receive. Medicare outlier payments are intended to ensure that health providers are fairly reimbursed for any extremely high cost patients that they treat. However, some IRFs receive a significant percentage of their total Medicare payments in the form of outlier payments despite having relatively lower average patient case-mix and length of stays. This could be an indication that outlier payments may be promoting inefficient care delivery.

65. Is it worth exploring a policy, similar to the one currently in place for home health agencies that would limit the total outlier payments an IRF can receive?

Answer: Inpatient rehabilitation facilities (IRFs) provide important services to Medicare beneficiaries with medically complex needs. Outlier policy has to have a balance between providing appropriate payment for services to beneficiaries who truly use resources beyond the average while making sure incentives aren't in place to identify too many services to beneficiaries as outliers. We will take your concern into account as we consider future outlier policy. We appreciate your interest in this benefit and would be happy to provide technical assistance on any proposals for its improvement.

<u>Third Party Payment for AHP Premiums</u>

The interim rule governing third party payment of qualified health plan premiums has created confusion for non-profit charitable organizations that are explicitly allowed by an HHS OIG ruling to provide financial assistance to Medicare beneficiaries. Although HHS issued an interim rule clarifying the acceptability of premium and cost-sharing payments made on behalf of enrollees by the Ryan White HIV/AIDS Program and other Federal and State government programs, it does not speak at all to the issue of non-profit patient assistance programs.
In fact, one plan in Louisiana is using the interim rule to justify a policy of <u>disallowing</u> non-profit patient assistance, which is particularly hurtful in a state that has not expanded Medicaid leaving more people facing affordability challenges, especially those with chronic diseases that most benefit from patient assistance programs.

66. Has HHS considered whether non-profit charitable organizations to provide financial assistance to enrollees in the Exchanges, applying the same standards developed by OIG for Medicare? Why is the rule different in this case?

67. Currently, how will HHS address the confusion of both patients and payers between the OIG policy applicable to Medicare verses how the interim rule issued by Exchanges is worded?

Answer to #s 66 and 67: As you note, the recent Interim Final Rule, Patient Protection and Affordable Care Act; Third Party Payment of Qualified Health Plan Premiums published in the Federal Register on March 19, 2014 did not require Qualified Health Plans and Stand-Alone Dental Plans to accept third-party payment from Non-profit organizations. However, previous guidance in the form of Frequently Asked Questions (FAQ's) issued on February 7, 2014 addressed this issue.

Specifically, in the February FAQ CMS addressed the question of whether a November 4, 2013 FAQ (which noted concern about third party payment and it's potential to skew the risk pool) applied to qualified health plan (QHP) premium and cost sharing payments on behalf of QHP enrollees from private, not-for-profit foundations.

In the February FAQ CMS noted that the concerns articulated in the November 4, 2013 FAQ would not apply to payments from private, not-for-profit foundations if: (a) they are were from Indian tribes, tribal organizations, urban Indian organizations, and state and federal government programs or grantees, or (b) if they are made on behalf of QHP enrollees who satisfy defined criteria that are based on financial status and do not consider enrollees' health status. In situation (b), CMS would expect that premium and any cost sharing payments cover the entire policy year. To be clear, the February 7, 2014 FAQ does not require QHPs and stand-alone dental plans to accept third party payment from private- non-profit foundations.

Senator Chuck Grassley

Questions for the Record:

340B Drug Program and HRSA Regulations

It has been reported that the Health Resources and Services Administration (HRSA) will issue new regulations on the 340B drug pricing program in June 2014. It is hoped that the new regulations will address several issues raised by the Office of the Inspector General in February 2014 about contract pharmacy arrangements throughout the program, as well as clarify aspects of the program to increase consistency and effectiveness.

68. Is HRSA working on new regulations to the 340B program?

Answer: Yes. HRSA is developing proposed regulations on the 340B Program.

If yes, please answer the following:

69. What is the status of the regulations?

Answer: The draft 340B Program proposed regulation is currently being reviewed by the Office of Management and Budget.

70. Will the regulations be subject to public notice and comment?

Answer: Yes. The proposed rule will be issued as a notice of proposed rulemaking and will be available for public comment for 60-days after the date of publication in the Federal Register.

71. When does HRSA anticipate the regulations will be publicly available?

Answer: We expect to publish the proposed regulation, which will be open for public comment, in this summer. The updated status of any review can be monitored at: www.reginfo.gov

72. What areas does HRSA plan to address in its regulations?

Answer:
Our longstanding policy is not to comment on regulations under review. That said, we would welcome you or your staff to come in and share your views on the rulemaking with us, and updated information on the status of any review can be monitored at: www.reginfo.gov.

Medicaid Tax

New actuarial standards were set to establish guidance and standards for actuaries preparing capitation rates under 42 CFR 438.6(c), and to establish guidance and considerations in the rate development process.

73. Do the new Actuarial Standards for Medicaid Managed-Care Capitation Rate Development and Certification specifically include a reimbursement or capitation rate adjustment for taxes paid by managed care plans under the Affordable Care Act?

Answer: Under current regulations, states are required to construct actuarially sound capitation rates which are subject to the Centers for Medicare & Medicaid Services (CMS) approval. Generally accepted definitions of actuarial soundness suggest that the rates provide for all reasonable, appropriate and attainable costs; costs include government-mandated assessments, fees and taxes. How to address these elements are left to reasonable determinations made by the state and approved by CMS.

74. Has CMS provided any guidance to states on this matter?

Answer: CMS is available to provide technical assistance to states as they develop actuarially sound capitation rates.

75. Is CMS currently engaged in any oversight to confirm that states are considering taxes paid by managed care plans under the Affordable Care Act in determining actuarial soundness?

Answer: CMS continues its review and approval of actuarially sound rates established by States in accordance with current regulatory standards.

HCQIS

The Centers for Medicare & Medicaid Services' (CMS) is scheduled to re-compete the Healthcare Quality Information Systems (HCQIS) IT Infrastructure Support contract as an 8(a) small business set-aside. While I am certainly supportive of small business opportunities, I am concerned that the scale, risk, and complexity of this work is not appropriate for a small business and needlessly puts at jeopardy many of the core federal healthcare payment reform efforts now underway. The size and scope of the HCQIS contract could make it an inappropriate fit for a small business to serve as prime contractor. While the program began as $2.3M/year contract it has now grown to over $70M/year.

76. How will a small business have the financial ability to draw down large lines of credit or the technical capability to manage the complex enterprise problems encountered when managing an environment like HCQIS?

Answer: The current contract for this work was awarded as a competitive 8(a) set-aside. If there is a reasonable expectation that offers can be obtained from at least two responsible small business concerns the procurement must be conducted as a set aside. In addition, in accordance with SBA guidelines when a procurement is awarded as an 8(a) contract, its follow-on or renewable acquisition must remain in the 8(a) Program.

CMS is now in the planning phase for the re-compete. The market research has been completed and the results support a reasonable expectation that the services required to support the HCQIS Infrastructure should remain in the 8(a) Program. In July 2013, CMS posted a sources sought notice on the Federal Business Opportunities site requesting eligible 8(a) firms to provide information on their capability to perform the required services needed for the HCQIS Infrastructure. CMS received several responses and the Contracting Officer provided those responses to the technical staff in the Center for Clinical Standards and Quality (CCSQ).

CCSQ assessed the responses from those eligible 8(a) firms and determined that there was a reasonable expectation that two or more of these firms were capable of performing the HCQIS

Infrastructure work. As part of its due diligence, CMS sought further clarification to ensure that these 8(a) firms had the ability and access to staff required to perform the work based on the current government need while also complying with the Limitations on Subcontracting as prescribed in the FAR Part 52.219-14. Given the results of this market research, CMS has determined that the HCQIS Infrastructure work should remain in the SBA 8(a) Program, and plans to conduct a competitive 8(a) set-aside procurement in the near future.

CMS actively tries to meet the government-wide goal that 23% of our funds obligated via contracts go to small business, where practicable.

77. By designating the procurement a small business set-aside, is it true that the winning contractor will not be allowed to bid on the following recompete at the completion of the period of performance due to its new size?

Answer: A firm must be an 8(a) contractor at the time of initial proposal submission to be eligible for a competitive 8(a) requirement. The Small Business Administration (SBA) determines the eligibility of the firm prior to award of an 8(a) competitive contract. The SBA has matched its size standards to the industry definitions found in the North American Industry Classification System (NAICS) manual. The size standard is basically the largest a concern can be and still qualify as a small business. The NAICS code that CMS used in our sources sought notice for the HCQIS Infrastructure was 541512 – Computer Systems Design Services. The size standard for this NAICS code is $25.5M in average annual receipts.

It is likely that the firm awarded the HCQIS contract will outgrow their size status or graduate from the 8(a) program during the life of this contract. If that happens, the work would still remain in the 8(a) program and the contractor would continue to perform the work. The contract would contain a clause requiring the contractor to re-represent its size status after a merger or acquisition, or at the end of the fifth year of a long-term contract.

The key issue here though is that the work is in the 8(a) program since the original contract for this work was competed as an 8(a) set-aside. Procurements that are already in the 8(a) program must remain in the 8(a) program unless released by the SBA. As previously mentioned, CMS conducted market research, using a sources sought notice in Federal Business Opportunities (FBO), to determine the capability of 8(a) small businesses to perform the HCQIS Infrastructure work.

Senator Mike Crapo

Questions for the Record:

In November, I asked you (Secretary Sebelius) if premiums both on and off the health care insurance exchanges were increasing. At that time, you said they were not. Then, you qualified that statement saying premiums were increasing at a slower rate than they would

have without the health care law. In fact, they were lower than they would have been without the law. In recent weeks, many insurers have commented that individuals in some areas of the country will see premiums double next fall. This is in part due to the lower than predicted enrollment of young, healthy individuals.

78. Do you believe enough young, healthy individuals have enrolled in the exchanges to keep premiums low?

Answer: Consistent with expectations, through March 1, 2014, the proportion of young adults (ages 18 to 34) who have selected a Marketplace plan through the SBMs and FFMs has remained strong. We expect that the robust enrollment numbers we are observing in the Marketplace's first year – 7.1 million as of April 1, 2014 – will encourage insurers to compete on price for consumers during next year's open enrollment period. In addition, provisions of the Affordable Care Act including premium mitigation tools like risk adjustment and reinsurance, more effective rate review and the medical loss ratio rule, will help protect consumers against unfair rate hikes.

79. Do you anticipate premiums increasing by double digit percentages?

Answer: We expect that the Affordable Care Act will continue to provide consumers with quality, affordable coverage options next year. The Affordable Care Act contains many tools to keep large premium increases in check. For example, the Affordable Care Act requires insurance companies to justify rate increase of 10% or more, shedding light on arbitrary or unnecessary costs and protecting consumers from unfair rate hikes. The rate review program works in conjunction with the 80/20 rule or Medical Loss Ratio rule, which requires insurance companies to spend at least 80 percent (85 percent in the large group market) of premiums on health care and quality of care efforts, and no more than 20 percent (15 percent in the large group market) on administrative costs such as executive salaries, marketing, and profits. Marketplaces premiums will also be moderated by the risk adjustment program, access to reinsurance, and the risk corridor policy.

80. Would you consider premiums doubling to be a greater increase than a typical year?

81. Do you agree these increases are greater than without the implementation of the health care law?

Answer to #80 and #81: Before the Affordable Care Act, consumers frequently saw double digit rate increases for their health insurance. The Affordable Care Act is contributing to a slowdown in health care spending growth. While some consumers may see increases, for many, these increases will be smaller than the double digit increases that were common before the Affordable Care Act.

Your budget proposes additional cuts to the Medicare Advantage program by increasing the minimum coding intensity adjustment to 8.51 percent in 2020. The health care law mandates over $200 billion cuts to the Medicare Advantage program.

82. What percentage of that amount has already been implemented?

Answer: Before the Affordable Care Act, Medicare Advantage plans were paid 114 percent of fee-for-service (FFS) Medicare costs on average, costing the program greater than $1,000 more per Medicare Advantage enrollee each year, while quality and health outcomes were similar to those enrolled in FFS Medicare. The changes in the Affordable Care Act revise payments to Medicare Advantage plans to be more consistent with costs in traditional Medicare, while incentivizing quality improvements by basing part of Medicare Advantage payment on plan quality performance.

The Affordable Care Act establishes a new methodology for calculating each MA county rate as a percentage of FFS spending in each respective county. The Affordable Care Act provides for a transitional period during which each county rate is calculated as a blend of the pre-Affordable Care Act rate and the new FFS-based Affordable Care Act rate. For 2015, most counties will be fully transitioned to the new rate methodology, while others will continue to be based on a blended rate.

The majority of the ACA Medicare Advantage benchmark and payment changes are represented in the 2015 ratebook and payment policies. The quality ratings and rebate elements have been fully implemented as well as a significant proportion of the other requirements. Provisions to be implemented in 2016 and later are:

- The phase-in of the specified rates for the six year transition counties will continue through 2017. Twenty-two percent of the counties, with 32 percent of Medicare Advantage enrollment in February 2014, have a six year transition.
- The minimum coding intensity adjustment will continue to increase until it plateaus in 2018, as required under the ACA and the American Taxpayer Relief Act of 2012.

Since the Affordable Care Act was passed in 2010:

- Medicare Advantage premiums have fallen by nearly 10 percent.
- Medicare Advantage enrollment has increased by 38 percent to an all-time high of more than 15 million beneficiaries, with nearly 30 percent of Medicare beneficiaries enrolled in a Medicare Advantage plan.
- Medicare Advantage enrollees are benefiting from greater quality with over half of enrollees now in plans with 4 or more stars, a significant increase from 37 percent of enrollees in such plans in 2013.
- Access to the Medicare Advantage program remains nearly universal, with 99.1 percent of beneficiaries having access to a plan in their area.
- The average number of plan choices remains consistent in 2014 compared to 2013 and access to supplemental benefits such as dental and vision benefits remains stable
- Over 90 percent of Medicare beneficiaries have access to a $0 premium Medicare Advantage plan.

- Approximately 80 percent of Medicare beneficiaries have access to a Medicare Advantage plan with Part D drug coverage with a yearly maximum out-of-pocket limit of $3,400 or less. All Medicare Advantage enrollees are in plans that will have a maximum out-of-pocket limit for all Medicare covered services of $6,700 or lower.
- 100 percent of Medicare beneficiaries – including Medicare Advantage enrollees – have access to Medicare-covered preventive services at zero cost sharing.

83. Why is CMS proposing additional funding cuts to the program when future cuts and the impact of those cuts on beneficiaries has not been realized?

Answer: In FY 2014, payments to Medicare Advantage plans are expected to cost the Medicare Trust Funds about $150 billion, with nearly 30 percent of Medicare beneficiaries enrolled in a Medicare Advantage plan. Given this size of the program, it is important that we look to ways to improve the accuracy of plan payments.

The Affordable Care Act (ACA) adjusted payments to Medicare Advantage plans to better align them with costs in the traditional Medicare program. The Budget builds on the ACA's reforms and addresses excess payments to these plans that have been identified by the Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC). For example, the Government Accounting Office (GAO) estimated that in 2010 MA beneficiary risk scores were at least 4.8 percent, and perhaps as much as 7.1 percent, higher than they would have been if the same beneficiaries had been continuously enrolled in traditional Medicare. The Budget's proposal to increase the minimum coding intensity adjustment would better account for this differential. . This proposal and others build on the Affordable Care Act's provisions, and we expect that plans' benefits and participation will remain strong.

In December, you informed industry stakeholders that the growth rate (per capita spending) for the combined effect of Medicare Advantage and fee-for-service would remain unchanged. In the February advance notice, the growth rate changed to -1.9 percent. By the April final notice, the growth rate had further decreased to -3.4 percent.

84. Can you provide data to account for these changes?

Answer: The early preliminary growth rate announced on the December 3, 2013 actuarial user group call was based on experience supporting the development of the Part A deductible and Part B premiums for 2014. Between the December 3, 2013 call and the release of the Rate Announcement in April, we updated our tabulation of historical fee-for-service (FFS) experience and revised the corresponding projection factors. The most significant change in the estimate was with respect to actual calendar year 2012 and 2013 inpatient utilization being lower than previously estimated. Similarly, the updated tabulation of Part B volume and intensity for 2012 and 2013 was also lower than the prior estimate, but less so than the reduction for inpatient utilization. The data for these calculations is available in Attachment II of the final Rate Announcement at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

Federal programs currently make graduate medical education (GME) payments to teaching hospitals and health centers based on eligibility, not based on a competitive process. Your budget proposes a new competitive grant program to teaching hospitals, children's hospitals and community-based consortia of teaching hospitals or other health care entities.

85. What standards will guide your determination of which entity receives awards?

Answer: The competitive process for the Targeted Support for GME Program, including the criteria and standards for making awards to applicants, is currently in the preliminary stages of development. The new program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, as well as care provided by an integrated team of clinicians. The program will help ensure that we are training future physicians in the settings where we know patients get the bulk of their care, as well as being trained in the models of health care delivery that are most effective.

86. Among competing residency programs, each with different goals, how would HRSA administer the grant program to achieve the Administration's stated goals of supporting ambulatory and preventive care, and increasing production of primary care physicians?

Answer: In competitive grant programs, the government identifies broad policy and program goals and applicants have the ability to develop proposals that address those goals while meeting regional and local needs. This encourages innovation in how training is conducted, and allows for programs to be tailored to meet specific needs. Grants are evaluated on the merit of the approach, as well as on program outcomes to ensure policy and program goals, as well as regional and local needs, are being met.

While residencies may vary somewhat since they relate to different specialties, they all should share the common goals of producing physicians that are well qualified to provide care in a changing health care environment that demands positive health outcomes be achieved more efficiently. Those will be key aspects of this program.

87. Can you comment on how this new program would benefit rural GME programs?

Answer: In a June 2010 report, (the Medicare Payment Advisory Committee (MedPAC) recommended changes to the nation's GME funding in order to support the workforce needed for a changing health care system, including providing residents with a broader set of training experiences and settings. The program builds on those recommendations by providing a range of experiences, including supporting rural GME programs, to address these needs.

You may also be interested to know about the Rural Physician Training Grant Program included in the President's FY 2015 budget request. The program seeks to increase the number of medical

school graduates practicing in underserved rural communities. The $4 million initiative will support the planning, development, and operation of a medical education program to encourage students to practice in these underserved areas.

Under your baseline estimates, the Medicare program is projected to spend $7.268 trillion over the next 10 years. In order to begin to control our Medicare spending, reforms to the method of scoring preventative health care must be considered.

88. Do you have any objection to CBO implementing dynamic scoring for health care legislation?

Answer: HHS does not have a position on the scoring rules established for the Congressional Budget Office.

89. In your opinion, would decreasing the prevalence of chronic conditions or ensuring the treatment of these conditions create savings in Medicare?

Answer: CMS is testing innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care for those individuals who receive Medicare, Medicaid, or CHIP benefits.

CMS' Independence at Home Demonstration is specifically focused on individuals with multiple chronic conditions. Under the Independence at Home Demonstration, selected primary care practices provide home-based primary care to targeted chronically ill beneficiaries for a three-year period. Participating practices will make in-home visits tailored to an individual patient's needs and preferences with the goal of keeping them from being hospitalized.

Home-based primary care may allow health care providers to spend more time with their patients, perform assessments in a patient's home environment, and assume greater accountability for all aspects of the patient's care. This Demonstration is designed to test if this focus on timely and appropriate care can improve overall quality of care and quality of life for patients served, while lowering health care costs by forestalling the need for care in institutional settings. The Demonstration will reward health care providers that provide high quality care while reducing costs.

Senator Michael Enzi

Questions for the Record:

Madam Secretary, your budget includes two legislative proposals that would affect at least 16 hospitals in Wyoming. One would cut reimbursement for these facilities from 101% to

100% of cost, and the other would eliminate Critical Access Hospitals that stand within 10 miles of another facility.

90. Can you explain why you view these proposals as necessary, given the issues with access to care in rural areas? What type of cost-benefit analysis did the Department undertake before putting these proposals in the budget?

Answer: The proposal to reduce Critical Access Hospital (CAH) reimbursement to 100% would generate savings to Medicare while ensuring that CAHs are paid based on their actual costs. The proposal to prevent hospitals within 10 miles of another hospital from maintaining designation as a CAH would ensure that only hospitals whose communities depend on them for emergency and basic inpatient care receive cost-based reimbursement. CMS does not expect either proposal would have any significant adverse impact on rural access to care. CMS's Office of the Actuary analyzed the budgetary impact of each proposal before their inclusion in the President's FY 2015 budget.

Another pair of proposals in the budget focus on increasing the size and range of the health care workforce. Your budget includes $4 billion in new funding for the National Health Service Corps and $5.2 billion for a competitive grant program related to graduate medical education. However, I'm curious to know how you plan to help states retain the health care professionals that are placed through these programs. In my experience, Wyoming received a fair amount of support for providers through the Health Service Corps, but nearly half of them do not stay in the state after five years from graduating from the program.

91. What work is being done to improve retention of graduates as opposed to simply throwing more money at the problem?

Answer: NHSC strategies to improve retention include encouraging peer-to-peer networking, publishing an electronic newsletter, maintaining a Facebook page, and utilizing NHSC Ambassadors as local resources for clinicians in the field. A 2012 retention assessment survey found that 55 percent of National Health Service Corps (NHSC) clinicians continue to practice in underserved areas 10 years after completing their service commitment. Another recent study completed in FY 2013 showed 85 percent of those who had fulfilled their service commitment remained in service to the underserved in the short-term. Short-term is defined as up to 2 years after their service completion.

Secretary Sebelius, I see that the new health care workforce programs touted in your budget, like expansion of the National Health Service Corps and the new Targeted Support for Graduate Medical Education, are included under the purview of the Health Resources and Services Administration (HRSA). However, according to recent GAO analyses of federal health care workforce programs, there are already over 90 programs in the federal government, including more than 50 within HHS, dedicated to improving the health care workforce.

92. Did the Department assess whether or not the proposals for new programs would be duplicative of existing efforts before including them in the budget? If not, why not?

Answer: Internal collaboration within and across HHS agencies occurs regularly. HHS also works with the Department of Defense (DoD), Department of Veterans Affairs (VA), and the Department of Education (ED) on a range of workforce issues, including working to ensure that programs are complementary, fill gaps, and avoid redundancies. For example:

- HRSA's National Health Service Corps (NHSC) program partners with HRSA's service delivery programs (e.g., Health Centers and the Ryan White Program) to increase access to primary care services in underserved areas. (The FY 2015 NHSC proposal expands a successful existing program.)

- HRSA collaborates closely with the Centers for Medicare & Medicaid Services (CMS) to ensure consistency and avoid duplication in payment policies across graduate medical education (GME) programs administered by each agency.

- HRSA partners with the VA and DoD to foster best practices in facilitating veteran transition to civilian health careers, including the development of bridge programs, tools for facilitating hiring of veterans, and strategies for removing barriers to licensure and credentialing.

The Targeted Support for Graduate Medical Education (TSGME) program will focus specifically on key priorities for workforce development and transforming the health care delivery system. For example, the program will focus on increasing training opportunities in community-based settings, as well as care provided by an integrated team of clinicians. Unlike the existing GME programs that provide payments but do not have any performance requirements, the TSGME program would use a competitive process to ensure funds were invested in those residency programs with the greatest promise of success that are addressing priority national needs. Continued funding would be dependent on successful performance.

93. Are there programs that should be reduced or eliminated as a result of the proposed expansion of the Health Service Corps or the new funding for graduate medical education?

Answer: The NHSC is unique in its ability to address the chronic problem of the national maldistribution of primary care clinicians in underserved communities and vulnerable populations by helping them recruit and retain the clinicians they need through the NHSC Scholarship and Loan Repayment Programs. The Targeted Support for GME program will help ensure that we are training future physicians in community-based settings, where we know patients get the bulk of their care, as well as being trained in the models of health care delivery that are efficient and effective, such as those that use technology and all the members of the health care team to provide comprehensive health care.

The Administration announced that it would begin open enrollment for the exchanges for the 2015 plan year on November 15, 2014. Conveniently, this date falls after Election Day this year and is over a month later than the traditional beginning of open enrollment seasons for health insurance plans, including the exchange.

My staff has spoken with several issuers and other stakeholders about the decision to move the date for open enrollment. None of them were not consulted with or informed of the prior to the announcement by the Administration.

94. Can you please explain why the Administration elected to begin open enrollment so late in 2014? Can you please explain why the Administration chose to not solicit input from insurers and other involved stakeholders before making this decision? Please provide any documents, memos, or other written information that would serve as a record of conversations with affected stakeholders.

Answer: As you know the *HHS Notice of Benefit and Payment Parameters for 2015*, which was published in the Federal Register on December 2, 2013, proposed, among other things that for all Marketplaces, annual open enrollment for the 2015 plan year would begin on November 15, 2014 and extend through January 15, 2015.

The proposed rule noted that the change would give health insurance issuers additional time to monitor 2014 enrollments prior to submitting their 2015 rates, particularly since first-year challenges in enrolling individuals could mean higher than expected enrollment toward the end of the initial open enrollment period. This expectation came to fruition on the final day of the first Open Enrollment period, March 31, when interest from consumers soared to a record-breaking 4.8 million visits to HealthCare.gov and about 2 million calls to federal Marketplace call centers. The proposed rule further noted that moving the beginning of the 2015 open enrollment period to November 15, 2014 will give issuers more time to review the claims experience in 2014, enabling them to set the rates for 2015 with greater precision.

After reviewing comments, HHS published the final Notice of Benefit and Payment Parameters for 2015 in the Federal Register on March 11, 2014 (79 FR 13744). The final rule amended the proposed rule by changing the end date of open enrollment for the 2015 benefit year to February 15, 2015. We believe that the additional time before open enrollment will enable the collection of additional rating experience that could have a positive benefit on reducing 2015 rates for consumers. We further believe that extending the open enrollment period to February 15, 2015 instead of January 15, 2015 is beneficial for consumers because it provides additional time to select a plan.

Secretary Sebelius, a number of my colleagues and I sent a series of letters to OMB expressing significant concerns with the Administration's treatment of certain self-insured plans under the rules for the reinsurance program. Specifically, we were concerned that the Administration would exempt certain insurance plans from paying the reinsurance fee, many of them union-sponsored plans, which would create the appearance of political favoritism.

Sure enough, the Administration has done just that.

95. Can you please explain why the Administration believed it was necessary to exempt these plans from paying the fee?

Answer: Section 1341(b)(1)(A) of the Affordable Care Act provides that "health insurance issuers and third party administrators on behalf of group health plans" must make reinsurance contributions. As a result, the final *HHS Notice of Benefit and Payment Parameters for 2014,* published on March 11, 2013 (78 FR 15410), requires all health insurance issuers and self-insured group health plans to submit reinsurance contributions for benefit year 2014.

Following comments submitted with respect to the 2014 Payment Notice and the proposed Program Integrity Rule (published on June 19, 2013 (78 FR 37032)), we began to reconsider the definition of a "contributing entity." We determined that Section 1341(b)(1)(A) could reasonably be interpreted in more than one way with respect to the applicability of reinsurance contributions to self-insured, self-administered group health plans. In the proposed, *HHS Notice of Benefit and Payment Parameters for 2015,* published on December 2, 2013 (78 FR 72322), the Department sought comments on a proposed modification to the definition of a "contributing entity" for the 2015 and 2016 benefit years to exclude self-insured group health plans that do not use a third party administrator for their core administrative processing functions—adjudicating, adjusting, and settling claims (including the management of appeals), and processing and communicating enrollment information to plan participants and beneficiaries. As a result, the proposed definition would exclude such self-insured, self-administered group health plans from the reinsurance fee in the 2015 and 2016 benefit years. After consideration of the comments on this provision, HHS finalized this policy in the final 2015 Payment Notice, published on March 11, 2014 (79 FR 13744).

96. Additionally, can you please explain why the remaining self-insured group health plans, many of which are plans held by small businesses, must pay this reinsurance tax without being eligible to receive any payments from it? How is this fair?

Answer: Section 1341(b)(1)(A) of the Affordable Care Act provides that "health insurance issuers and third party administrators on behalf of group health plans" must make reinsurance contributions. The Department finalized a revised definition of contributing entity in the final 2015 Payment Notice, published on March 11, 2014 (79 FR 13744) for plan years 2015 and 2016. Section 1341(b)(1)(B) further directs that reinsurance payments are to be made to health insurance issuers "that cover high risk individuals in the individual market (excluding grandfathered health plans)" and the Department's regulations follow this statutory directive.

Senator John Thune

Questions for the Record:

The bipartisan Quality Data, Quality Healthcare Act (S. 1758), which I introduced with Senator Tammy Baldwin, would provide for greater access to Medicare claims data by reforming the Medicare Qualified Entity program. The legislation would: allow organizations receiving Medicare data to analyze and redistribute data to authorized subscribers, including insurers, health systems, employers, and physicians, so that subscribers can make more informed healthcare decisions; and permit those entities to charge a fee to their subscribers so that the organizations can conduct robust analyses to improve healthcare quality and reduce costs.

The President's budget support many of the reforms in the Quality Data, Quality Healthcare Act. Like S. 1758, the budget proposal would expand the scope of how qualified entities can use Medicare data by allowing entities to use the data for fraud prevention activities, value-added analysis for physicians, as well as releasing raw claims data to interested Medicare providers for care coordination and practice improvement.

This week, CMS publicly released raw Medicare claims data for individual physicians in 2012. While this public release of one year of Medicare claims data represents a commitment to increasing healthcare transparency, the dataset has limitations as acknowledged by CMS. For one, the data are not intended to indicate the quality of care provided and are not risk-adjusted to account for differences in underlying severity of disease of patient populations. Further, release of this data does not effectuate the policy changes called for in S.1758 or the President budget.

97. Can you please describe the value in making Medicare data regularly available to qualified entities and those organizations that are best equipped to analyze and use the information for quality purposes?

Answer: The President's budget proposal would expand Medicare data sharing with qualified entities, enabling the entities to use the data for other purposes in addition to measuring provider performance. Specifically, the proposal expands the scope of uses for which "qualified entities" can use Medicare data beyond just provider performance. This proposal would enable these entities to use the data for other purposes, such as fraud prevention activities and value-added analysis for physicians. In addition, qualified entities would be able to release raw claims data, instead of only releasing summary reports, to all interested Medicare providers for care coordination and practice improvement. This proposal includes additional resources for CMS by making claims data available to a qualified entity for a fee equal to Medicare's cost of providing the data. The proposal could improve the Medicare program for beneficiaries in that these entities could use claims data to help providers improve their practices and better coordinate care.

98. How will empowering qualified entities to better utilize and redistribute data to subscribers also help consumers in understanding healthcare spending and practice patterns, as well as increase healthcare efficiency, improve quality, and reduce costs?

Answer: The President's budget proposal would expand Medicare data sharing with qualified entities, enabling the entities to use the data for other purposes in addition to measuring provider performance. Specifically, the proposal expands the scope of uses for which "qualified entities" can use Medicare data beyond just provider performance. This proposal includes additional resources for CMS by making claims data available to a qualified entity for a fee equal to Medicare's cost of providing the data. The proposal could improve the Medicare program for beneficiaries in that these entities could use claims data to help providers improve their practices and better coordinate care. Expanding the scope of uses for which qualified entities can use Medicare data may make the program more attractive to potential applicants. With more participants in the program, more providers and beneficiaries would benefit.

Senator Richard Burr

Questions for the Record:

I understand four states – Florida, North Dakota, Oklahoma, and Wyoming – by actions of their state governments have rejected MIECHV funding, yet HHS is currently granting funds to non-profit entities to continue providing services to children and families in those states.

99. What selection criteria and, which non-profit grantees, were chosen to provide services in those states?

Answer: In instances where a state chooses not to directly implement the Home Visiting Program, the authorizing statute provides the Secretary the authority to fund a nonprofit organization to conduct an early childhood home visitation program in that state. In those circumstances, HRSA conducts a competitive process for eligible non-profit organizations whereby applicants propose to implement a home visiting program in the state. The application and review process track the statutory requirements and accord with the HHS Grants Policy Statement.

Eligible applicants are non-profit organizations with an established record of providing early childhood home visiting programs or initiatives. Applicants must demonstrate that they will provide home visiting services to families in at-risk communities as identified in the home visiting statewide needs assessment conducted by the state. General expectations for a non-profit grantee parallel those for a state-based award.

The selection criteria for the Home Visiting Program non-profit grantees are generally the same as those used for states. They consider the proposed activities and their impact as well as the plan for data collection and evaluating the success of the program's activities. For non-profit

grantees, the resources and capacity of the organization are considered. These factors are assessed by a panel of independent experts as part of the competitive grants process.

Currently, nonprofit organizations in four states (Florida, North Dakota, Oklahoma, and Wyoming) are receiving or are eligible to receive funding through the Home Visiting Program.

The current non-profit grantees include:

- Florida Association of Healthy Start Coalitions
- Prevent Child Abuse, North Dakota
- Parents as Teachers National Office (Wyoming)

The application period for the funding of a non-profit organization in Oklahoma closed on April 18, 2014; therefore, the applications received through this announcement are still under review.

Senator Johnny Isakson

Questions for the Record:

I am very troubled by this Administration's continued proposals to cut the Medicare Advantage program. Nearly 400,000 Georgia seniors are enrolled in Medicare Advantage, and they appreciate the value-added benefits, care coordination, and choices that are available through MA. President Obama's health care law included devastating cuts to MA that are only in the early stages of being phased in. Furthermore, the Administration and CMS continue to put forward proposals for additional Medicare Advantage cuts, on top of the Obamacare cuts.

Many of these proposals seem to be based on an assumption that Medicare Advantage plans are getting overpayments through gaming the risk adjustment system. However, a recent Milliman study found that MA plans are actually underpaid, relative to fee-for-service, for many of the highest-risk beneficiaries. The underpayment is 2 percent for dual eligibles, 7 percent for patients with chronic kidney disease, 20 percent for institutionalized beneficiaries over age 80, and so on. These are the very people who stand to gain the most from the improved care coordination that Medicare Advantage offers. I appreciate that CMS pulled back its proposal to restrict MA plans' use of home risk assessments. But the President's FY 2015 budget includes another proposal to cut Medicare Advantage by an additional $31 billion by reducing risk adjustment payments for chronically ill beneficiaries.

100. **As you know, the Medicare Payment Advisory Commission (MedPAC) has recommended changes to the risk adjustment model to make it more accurate, such as factoring in a beneficiary's total number of chronic conditions. When will the Administration start considering proposals like this to ensure that Medicare Advantage plans are adequately incentivized to enroll the highest-risk beneficiaries,**

instead of using the risk adjustment model as a tool to push additional Medicare Advantage cuts?

Answer: CMS is concerned that MedPAC's proposals for changing the risk model might not actually improve payment for these populations, and might introduce other weaknesses into the risk adjustment model. CMS periodically evaluates and updates the model and we will consider MedPAC's recommendations as part of these evaluations.

When you testified before this committee last fall, I asked you about the astonishingly high premiums for Obamacare coverage in rural southwest Georgia. For many residents of rural areas, the "Affordable Care Act" is proving to be anything but affordable. Your response at the time was that rates would go down as more insurance plans entered these markets. We are less than two months away from the deadline for insurers to submit bids for 2015, and I am not aware of any influx of new competition into southwest Georgia. However, a March 19 article in The Hill titled "O-Care premiums to skyrocket," quotes insurance officials stating that rates are likely to double or even triple in some parts of the country. According to the article, "areas of the country with older, sicker, or smaller populations are likely to be hit hardest."

101. For families in rural southwest Georgia, the cheapest "bronze" plan already has a premium of over $12,000 per year – and that's for a plan with a $12,600 deductible. Do you believe this constitutes affordable coverage?

Answer: The lack of competition in some rural markets predates the Affordable Care Act. The Affordable Care Act offers all consumers, including those in rural Georgia tools to make insurance more affordable. For example, insurance affordability programs, including premium tax credits and cost-sharing reductions, will help many eligible individuals and families, significantly reducing the monthly premiums and cost-sharing paid by consumers. Premium tax credits may be paid in advance and applied to the purchase of a QHP through the Marketplace, enabling consumers to reduce the upfront cost of purchasing insurance. In addition, cost-sharing reductions will lower out-of-pocket payments for deductibles, coinsurance, and copayments for eligible individuals and families. In fact, as of March 1, 83 percent of those who have selected a Marketplace plan have selected one with financial assistance. I encourage consumers to compare their plan options including premium and the out-of-pocket costs associated with the different plans in their area.

102. What evidence do you have to support the claim that more insurance companies are preparing to enter the health insurance exchange in rural areas such as southwest Georgia?

Answer: A major problem in the previous insurance market had been a lack of competition in some areas, especially rural ones. In many states, we have seen new issuers offering plans on the Marketplace that were not offering plans before, and we hope that in future years, the number of issuers will continue to increase.

The HHS "Budget in Brief" includes a summary of mandatory spending under the President's budget proposal. In addition to Medicare, Medicaid, and other established programs, the summary contains a line for "other mandatory spending," which more than doubles from $6 billion in 2013 to $12.6 billion in 2014, and then doubles again to $24.6 billion in 2015.

103. What is the total amount of <u>new</u> mandatory spending on health care that the President is proposing over the next 10 years?

Answer: The President's fiscal year (FY) 2015 Budget for HHS includes investments needed to support the health and well-being of the nation, and legislative proposals that taken together would save an estimated $355.6 Billion in scoreable savings, subject to PAYGO, over 10 years. The FY 2015 President's Budget builds on the Affordable Care Act by including additional health savings that will strengthen Medicare and Medicaid and other Federal health programs by implementing payment innovations and other reforms that encourage high quality and efficient care. The FY 2015 Budget also proposes several new mandatory initiatives within the Health Resources and Services Administration, the Administration for Children and Families, and the Administration for Community Living. Enclosed is a table detailing the new mandatory health care programs proposed in the FY 2015 President's Budget and the associated cost or savings over the next 10 years. Savings on the table include Program Integrity initiatives; these amounts do contribute to deficit reduction, but on a non-PAYGO basis.

On April 7 the President signed into law bipartisan legislation, sponsored by Senator Casey and myself, to reauthorize the Children's Hospital Graduate Medical Education program. This is a rare piece of health care legislation that has overwhelming bipartisan support in both the House and Senate. Therefore, I find it troubling that the Administration's budget proposes to terminate this successful program and transfer support for children's hospitals to a new mandatory program that appears to duplicate existing Medicare subsidies for medical education. Congress created CHGME because children's hospitals do not receive the Medicare subsidies that other teaching hospitals receive. As a result, the CHGME program supports training for half of our pediatric workforce.

104. It is my understanding that Medicare already pays significantly more per resident than children's hospitals receive through CHGME. Why would the Administration propose to take money away from a successful bipartisan program and give it to teaching hospitals that are already well subsidized?

Answer: The Targeted Support for Graduate Medical Education (GME) program will continue to support graduate medical education in children's hospitals. The program includes a $100 million set-aside for 2 years to be distributed to children's hospitals using the existing CHGME formula to support the current residency training programs, including pediatric subspecialties and other types of specialists who may be presently supported. This is $12 million more per year than prior budget requests, places the program on the mandatory side of the budget and provides a two-year commitment to children's hospitals as opposed to year-by-year discretionary appropriations. Children's hospitals will not be limited to the $100 million set-

aside as they may also apply for funding through the Targeted Support for GME competition process.

When Obamacare was going through Congress, the former Speaker of the House famously said that we had to pass the law to find out what's in it. My constituents have certainly seen a number of unpleasant surprises as this law has been implemented, and I believe another big one is coming in a year when the 2014 tax filing season arrives. When Massachusetts implemented its health care overhaul, the state department of revenue mailed a postcard to 3 million tax filers informing them that they needed to "act now to avoid tax penalties." Yet the Administration's outreach and advertising on Obamacare has been conspicuously silent on the new tax that Americans will have to pay next year if they don't have government-approved health insurance.

105. Do you believe HHS has done an effective job of informing the public about these looming tax penalties, and specifically the fact that most people without insurance will have to pay far more than the $95 figure that is often quoted for year one?

Answer: The Department has worked hard over the past year to communicate to all Americans the benefits of purchasing health coverage through the new Health Insurance Marketplaces. In addition to describing the important improvements the Affordable Care Act has brought, information is available on the requirement for most Americans to purchase minimum essential coverage, or pay an individual responsibility payment. Consumer information has been made available through different sources, including Healthcare.gov and the Internal Revenue Service. As you know, the shared responsibility payment for individuals without minimum essential coverage is implemented by the Department of Treasury and Internal Revenue Service, so I respectfully refer you to them for additional details

<u>Senator Rob Portman</u>

<u>Questions for the Record:</u>

<u>Durable Medical Equipment (DME) Competitive Bidding</u>

The President's FY 2015 budget includes a proposal to limit Medicaid reimbursement of Durable Medical Equipment based on Medicare rates. During the Senate Finance Committee mark-up of legislation to repeal and replace the Sustainable Growth Rate, I, and a bipartisan group of my colleagues, led an effort to include language requiring that bidders prove that they are licensed in the state before they can supply equipment through the program. This lack of a state licensure requirement has continued to be an issue in Ohio and several other states.

This requirement was not included in the temporary patch that passed the Senate last week, but I continue to think this is a critical issue to ensure that seniors have access to crucial equipment, such as oxygen tanks and wheelchairs.

106. Given that the Administration is proposing to expand the pricing determined through competitive bidding, will you work to clearly establish a requirement that bidders prove state licensure prior to submitting bids?

Answer: Suppliers submitting a bid for a product category in a competitive bidding area (CBA) must meet all DMEPOS (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies) state licensure requirements and other applicable state licensure requirements, if any, for that product category for every state in that CBA. Every supplier location must be licensed in each state in which it provides services. Suppliers are evaluated based on state licensure requirements in place at the time of bidding.

Contracts are only awarded to suppliers that meet applicable state licensure requirements. Contract suppliers must maintain compliance with all licensure requirements throughout the duration of the contract period. Licensing requirements change periodically and it remains the responsibility of the contract supplier to identify and obtain all required licenses. Failure to comply with these requirements is a breach of contract and may result in contract termination, the revocation of Medicare billing privileges, and other significant penalties.

<u>Medicare Advantage FY 2015 Rates (AHIP)</u>

The FY 2015 final notice for Medicare Advantage included estimates of the FFS Growth Percentage and National Per Capita MA Growth Percentage (NPCMAGP) used to calculate MA payments. In December 2013 the Office of Actuary indicated that the growth rate would be flat for the next year. Furthermore, in the 2015 Advance Notice CMS indicated that the growth rate would be -1.9%. However, the growth estimates in the final notice were lowered to -3.4%.

107. What accounts for the dramatic difference in growth rates projections over a few months?

Answer: The early preliminary growth rate announced on the December 3, 2013 actuarial user group call was based on experience supporting the development of the Part A deductible and Part B premiums for 2014. Between the December 3, 2013 call and the release of the Rate Announcement in April, we updated our tabulation of historical fee-for-service (FFS) experience and revised the corresponding projection factors. The most significant change in the estimate was with respect to actual calendar year 2012 and 2013 inpatient utilization being lower than previously estimated. Similarly, the updated tabulation of Part B volume and intensity for 2012 and 2013 was also lower than the prior estimate, but less so than the reduction for inpatient utilization. The data for these calculations is available in Attachment II of the final Rate Announcement at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf

108. How was utilization factored into the calculation? Why is this so different than past years, especially when CMS accounts for historical data in its trend?

Answer: The most significant change in the estimate was with respect to actual calendar year 2012 and 2013 inpatient utilization being lower than previously estimated. Similarly, the updated tabulation of Part B volume and intensity for 2012 and 2013 was also lower than the prior estimate, but less so than the reduction for inpatient utilization. As mentioned above, the update provided in the April 2014 notice reflects more complete program experience. When the 2014 rates were finalized in April 2013, complete 2012 experience data was not yet available and projections had to be made for 2013 and 2014. The most significant prior year corrections included in this notice include a more complete 2012 experience, more 2013 actual experience, and an update to the 2014 projected experience.

Independent Payment Advisory Board

The Independent Payment Advisory Board was created in the Affordable Care Act in an attempt to slow the growth of Medicare costs. The FY 2015 budget includes a proposal that would lower the savings target the IPAB must meet for 2018 and after from gross domestic product (GDP) per capita growth plus 1 percentage point to GDP per capita growth plus 0.5 percentage points. In the FY 2015 budget proposal, HHS estimates this proposal will produce $12.9 billion in savings over 10 years.

109. In the President's FY 2014 budget, the same proposal was estimated to save $4 billion over 10 years. Where does the $9 billion difference between the FY 2014 and FY 2015 proposals come from?

Answer: The Independent Payment Advisory Board (IPAB) serves as a backstop to protect against excessive cost growth in the Medicare program. The proposal in the President's FY 2015 Budget would strengthen IPAB to further bring down Medicare cost growth in a manner that protects beneficiaries and upholds the fundamental compact that the Medicare program represents. While it is the same proposal that was included in the FY 2014 President's Budget, the difference in scoring can largely be attributed to the FY 2015 budget window, which provides an additional year for the proposal to generate savings.

110. Both the Congressional Budget Office and the Medicare trustees agree that the Medicare program is running permanent deficits and will never come into balance absent reform. Given this dire fiscal situation, exactly how long will IPAB extend the solvency of the Medicare program?

Answer: The Independent Payment Advisory Board (IPAB) serves as a backstop to protect against excessive cost growth in the Medicare program across the Medicare program. IPAB may not propose increases in cost-sharing or beneficiary premiums, restrictions on benefits, rationing of health care, or changes in eligibility, but in the long run, otherwise may propose changes that would rein in spending across the program. As we cannot predict what proposals IPAB will

recommend, we cannot estimate its impact on the solvency of the Medicare Hospital Insurance Trust Fund. However, the CMS Actuaries have estimated that, if enacted, all of the Medicare proposals in the President's Budget would extend the life of the Medicare Hospital Insurance Trust Fund by approximately five years.

Part D Rule

This past February I joined a majority of the Senate Finance Committee in sending a letter to Administrator Tavenner regarding the Part D proposed rule for the 2015 contract year. Our letter expressed strong concerns that the proposed rule would fundamentally restructure Part D and could result in a significant loss of beneficiary choice, access, and consumer protections. Subsequently, the Administrator announced that CMS does not plan to finalize these proposals "at this time."

I appreciate CMS' decision to not finalize the proposals, but the phrase "at this time" concerns me. This committee will continue to be vigilant on these issues in order to protect the Part D program and its enrollees.

111. Does CMS have plans to move forward with these proposals at some point in the future?

Answer: The proposed rule included many important provisions related to the Medicare Part C and D prescription drug program. During the rule's comment period, we received numerous concerns about some elements of the proposal from members of Congress and stakeholders. In particular, we heard concerns about the proposals to lift the protected class definition on three drug classes, to set standards on Medicare Part D plans' requirements to participate in preferred pharmacy networks, to reduce the number of Part D plans a sponsor may offer, and clarifications to the non-interference provisions. Given the complexities of these issues and stakeholder input, we do not plan to finalize these proposals at this time. We will engage in further stakeholder input before advancing some or all of the changes in these areas in future years.

112. Would you be willing to work with the committee and relevant stakeholder groups before considering moving forward with these proposals in the future?

Answer: We are committed to continuing to work with Congress to continue to ensure that the Part D program works best for Medicare beneficiaries while remaining affordable. We look forward to working with you through our future rulemaking process and pledge our assistance as Congress considers any adjustments to these programs.

Medicare Testing Supplies

Federal regulations include an "anti-switching" provision which prohibits contract suppliers from influencing or incentivizing beneficiaries to switch their current glucose

monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor currently in use by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors. The beneficiary may engage the contract supplier about alternative brands and the supplier can describe what brands it offers; however, the supplier cannot be the one to initiate this conversation.

Patients requiring diabetic testing supplies have raised significant concerns about their glucose monitor and testing supplies being switched by contract suppliers. Specifically, beneficiaries have reported that they have been sent DTS products without consent, furnished meters and supplies that may raise quality concerns, and were given incorrect information from suppliers and Medicare.

113. What is CMS doing, short term and long term, to correct these issues in the program?

Answer: Medicare rules include an "anti-switching" provision as a term of the contract for suppliers under the national mail-order competition for diabetic supplies. This regulation prohibits contract suppliers from influencing or incentivizing beneficiaries to switch their current glucose monitor and testing supplies brand to another brand. The anti-switching rule requires contract suppliers to furnish the brand of testing supplies that work with the monitor selected by the beneficiary. This rule was established to protect beneficiary and physician choice of glucose monitors.

CMS has implemented a robust monitoring program to track and resolve any issues that might occur with program implementation. Extensive real-time monitoring data have shown successful implementation with very few beneficiary complaints and no negative impact on beneficiary health status based on measures such as hospitalizations, length of hospital stay, and number of emergency department visits compared to non-competitive bidding areas. We will continue to monitor access to quality products and promptly address any issues.

All Medicare DMEPOS suppliers must furnish items that meet applicable FDA regulations and medical device effectiveness and safety standards. In order to furnish any DMEPOS for Medicare beneficiaries, all suppliers must be in compliance with the Medicare supplier standards and quality standards. The Medicare quality standards require suppliers to implement a program that promotes the safe use of equipment. If a Medicare DMEPOS supplier furnishes items that do not comply with FDA standards or Medicare standards and requirements, we will implement corrective action in accordance with our existing authorities and remedies.

If a beneficiary is having any issues with diabetic testing products or other durable medical equipment furnished by a Medicare contract supplier, he or she should contact Medicare at 1-800-Medicare to report this issue so that appropriate actions can be taken.

114. When beneficiaries are sent supplies that they did not want or order, what steps are taken to make sure the beneficiary gets the diabetes testing supplies they need in a timely manner?

Answer: If a beneficiary is sent incorrect supplies by their supplier, the beneficiary should contact the supplier immediately about this issue. If the supplier does not send the correct supplies or product, the beneficiary should contact Medicare at 1-800-Medicare to report this issue and Medicare will help the beneficiary resolve it.

115. How many beneficiaries have been reimbursed for supplies they did not want or order, and later returned?

Answer: CMS monitors and oversees contract supplier performance through a variety of mechanisms, including complaint monitoring, real-time claims analysis, and secret shopper calls. While we have received a small number of isolated complaints from beneficiaries who wanted to return supplies, we have not seen indications of systemic issues.

Wyden Statement on President's Budget for Fiscal Year 2015
for the Department of Health and Human Services

This morning, we are here to discuss the health care proposals in the President's fiscal year 2015 budget. Madame Secretary, thank you for joining us this morning to testify.

This discussion will undoubtedly trigger some debate about the Affordable Care Act. Certainly there will be some reasonable differences of opinion, but I'd like to start with a handful of overlooked facts that are not in dispute about what's happened since the Affordable Care Act became law.

First, with the passage of the law, health care in America is no longer just for the healthy and the wealthy. Before the law was enacted, insurance companies could discriminate against people with pre-existing conditions. That meant that those who were healthy had nothing to worry about; those who were well-off could pay their bills; and everybody else went to bed worried they could be wiped out financially.

Second, the rate of growth in Medicare is slowing. The fact is that according to Health and Human Services data, annual Medicare spending per senior grew by 1.9 percent over a two-year period – slower than overall economic growth and much slower than historic growth. Over the previous three decades, per-senior spending grew 2.7 percentage points *faster* than the economy. This has the potential to be great news for seniors who want lower premiums, and for taxpayers who want to extend Medicare without breaking the bank.

Third, there are some important reforms that have been launched over the past few weeks. For example, building on work members of this committee have done to open the Medicare database to Americans, the Obama Administration yesterday made public unparalleled amounts of information that will help Americans make choices about their health care.

This will help fight fraud, promote competition for Medicare Services and be a useful tool for the private sector. This information can be used by private employers and others to bring down the cost of insurance.

Another recent and promising announcement helps provide patients with life-threatening illnesses with more choices in care. For the first time, patients will have access to hospice care without having to give up the prospect of curative treatment. This puts patient and families first, and it's high time.

Fourth, Congress now has a bipartisan, bicameral game plan for dealing with chronic disease. Senator Isakson and I have legislation focused on improving care for seniors with multiple chronic conditions. It's the most-expensive and fastest-growing portion of the Medicare population, and these seniors deserve better care.

Fifth, there's plenty of debate about which Americans enrolled in the Affordable Care Act and when, but the independent data shows that the number of uninsured is significantly lower than it has been in years. For example, a Gallup poll released this week shows that the rate of uninsured Americans fell to the lowest level since 2008.

Finally, Congress has made real progress on permanently repealing and replacing the broken and dysfunctional Medicare physician payment formula. The reforms agreed to would push Medicare to be driven by the quality and value of care. Today's volume-driven care isn't good for seniors, their doctors or Medicare itself. The President's budget proposal endorses the bipartisan, bicameral reform package, and I look forward to working with Secretary Sebelius to help push this over the finish line by year's end.

Madame Secretary, the last time you were here before the Finance Committee, I compared the rollout of the Affordable Care Act to the expansion of Medicare to provide prescription drugs to America's seniors during the Bush Administration. Like the Affordable Care Act, it zeroed in on the same concerns: expanding coverage, financial assistance to the needy, increased marketplace choices.

Medicare Part D has been a huge success, a God-send to millions of seniors, and it has cost 30 percent less than the Congressional Budget Office predicted. However, it had a very bumpy start, and many of the news stories from those early days of Part D resemble what we've seen with the Affordable Care Act. But with Congress working across the aisle to make it work, Medicare's prescription drug program was able to get off the ground and become the success it is today.

And, like the Medicare drug benefit, millions of Americans now have the economic security of health insurance they didn't have just a few years ago. Regardless of politics or feelings about this law, that's something that's good for the economy, and for the country.

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